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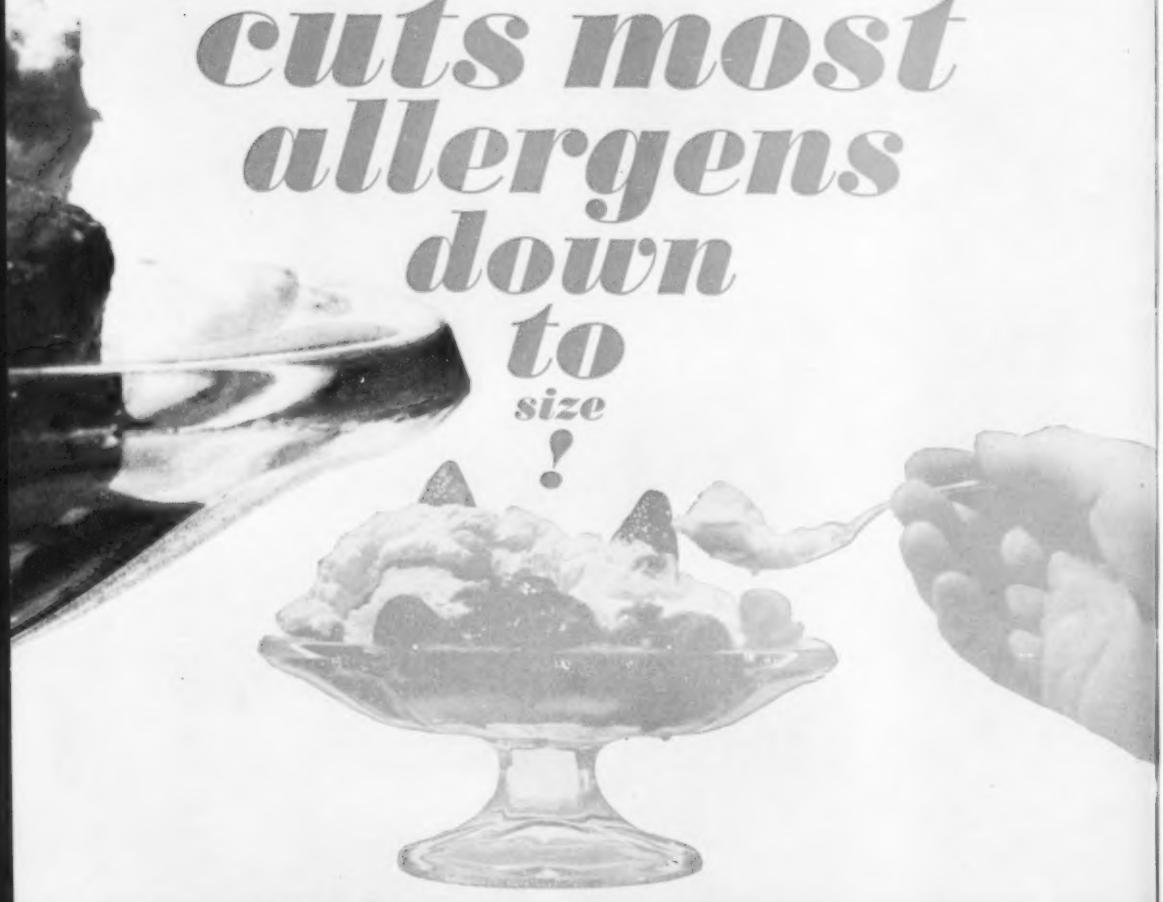

EDITORIALS

THIS YEAR'S TOPIC for all intercollegiate debate teams, Compulsory Health Insurance, presents an opportunity for all doctors who are qualified to get into the front line trenches.

The Patient-Doctor Relationship

The need for a sound patient-doctor relationship, based upon a bond of mutual trust, has always been stressed. How does Socialistic (you can put more vinegar into your enunciation of "socialistic" than you can "socialized") Medicine ruin a desirable relationship?

Compulsion is, and should be, odious to most Americans. Compulsion should have no part in most phases of life. No one can be compelled to be devout to God. No one anywhere in the world, including Russia, should be compelled to refrain from being devout to God. A child can be compelled to go to school, but no one can be compelled to learn.

The patient-doctor relationship is a delicate mechanism. If compulsion enters any phase of it, the bond of mutual trust is broken. It cannot exist if the doctor is under compulsion; it cannot exist if the patient is under compulsion.

That bond of mutual trust is broken if a compulsory tax is collected and used to pay for medical services. Four traits of human nature—facts of life—demonstrate this. First is the trait which causes people to demand a return for money (even for insurance premiums and taxes!) which they have paid in. This is demonstrated by the way people, who have little or nothing wrong with themselves, flock to the doctor in all countries which have socialistic medicine. Next, bearing upon that factor and making it easier to be a malingerer, is the fact that if you say you have a headache, or any of many other complaints, no one can prove or disprove that you have a headache. All countries which have socialistic medicine continually battle against "over-prescribing." Thirdly, under socialistic medicine, you pay in one commodity, money, and draw out an entirely different commodity, medical service. Your money was tangible; your medical services are not tangible.

Finally, bearing upon that factor and adding to any patient's dissatisfaction, is the fact that there is no yardstick with which to measure the value of medical services. Your doctor might see you once and save your life; he might see you every day for a year and you not feel any measurable benefit.

It will always be true that sick people suffer neglect, that the patient is always the loser under any form of socialistic medicine. That should be the keynote of all our arguments against socialistic medicine.

L. T. Brown, M.D.

Crisis in American Medicine?

AS PRESIDENT of the Colorado State Medical Society, Dr. Cyrus Anderson has urged us to appraise the magazines on our reception room tables. He urged that we should particularly note wether we are lending tacit endorsement to those which are critical of American medicine—particularly Look and Harper's, notorious offenders. We have also been warned of this unwitting error on our part by Dr. Morris Fishbein, formerly editor of the J.A.M.A. and now editor of Medical World News. The magazine "Look" has capitalized upon alleged scandals within hospitals and at the hands of supposedly incompetent surgeons. Harper's has asked why the shortage of doctors "with no plan to fill the gap," while ignoring plans for new medical schools. It has also asked why the family doctor is in danger of becoming extinct, ignoring membership of

30,000 in the American Academy of General Practice. It has asked why our hospitals are on the verge of bankruptcy, ignoring about 150 new hospitals built each year since 1947 with Hill-Burton funds matched by the communities. And furthermore, it asks why the political parties made a major issue out of the government having to do something about rising costs of medical care for old people, ignoring the fact that the oldsters require two to three times as much medical service as others, that they now comprise 10 per cent of the population compared with 3 per cent 50 years ago, and the fact that we have done many things to help them. Believing as we do in the American way, we have originated and promoted means of helping them to help themselves. Unscrupulous magazines, aiming at sensationalism, exploit dangerous and unwarranted criticism which our profession neither needs nor deserves.

The so-called crisis in American Medicine is not nearly as great as our critics would have the people believe. A great profession with strong traditions cannot change suddenly—particularly when opposed by politicians whose philosophy is contrary to maintaining for America the best medical care on earth.

There are many projects upon which we are embarked for improving medical education and practice, and others are in the making. We shall continue our efforts to attract more and better doctors into the profession, maintain the dignity of general practice, perpetuate the hospital construction program and apply the free enterprise system and free choice of physicians. Research in our own and ancillary institutions will, of course, continue.

Let us not forget a relatively minor, but not inconsequential, personal obligation to our patients, our profession, and ourselves: We can maintain a dignified and high type reception room with a choice of reading material not inimical to the best interests of our patients and survival of the best medical practice in the world. Since Dr. Anderson thoughtfully reminded us of the implications—damaging to our patients—of a poor choice of reading material in our offices, a critic has sent in a letter to a reader's forum of a regional newspaper. In addition to being totally misinformed, the communicant obviously is prejudiced against physicians. He accuses Dr. Anderson of selfish motives, something foreign to the altruistic and dedicated man that he is. It is disappointing to note how many little minds there are—and how they reach out for something, or anything, about which to carp. They choose strange ways to bolster their unhappy ego!

Maintain the Art Of Medicine

An editorial in a recent issue of Medical Science presents some pointed comments upon the so-called "dehumanization" of medicine, with emphasis upon the "lost art" of percussion and auscultation in favor of laboratory tests and mechanical examination. It claims our powers of observation have become dulled—and we are inclined to treat the patient as a hole (*without* the "w"), a hole which has come to receive gallons of contrast media and test substances and from which large amounts of fluids are drawn for the purpose of testing. Some of today's physicians seem to have forgotten what the oldtimers had to know: That laboratory data are only confirmatory, valueless without adequate history and thorough physical examination. Every person who is told that he has a disease develops component signs or symptoms based upon his natural concern. Most of these can be quickly ameliorated by the physician who clearly states the realistic prognosis and the principles upon which treatment is based. Without this consideration, and with a lot of more or less uncomfortable and expensive tests, a poor brand of medicine would be practiced.

Just as there is no sharp line of demarcation between reality and unreality, between sanity and insanity, there is no separating laboratory and nonlaboratory methods. The editorial exhorts us to "treat the patient as a whole," not a hole. The better physicians will first study all of the symptoms—and the entire patient—and then treat the parts that need it.

Intraperitoneal Neomycin in peritonitis

Francis A. Barrett, M.D., Cheyenne, Wyoming

This effective antibiotic drug appears to be life-saving in selected cases of fulminating peritonitis. Its potential dangers are stressed.

WAKSMAN[15] IN 1949 ISOLATED THE ANTIBIOTIC, Neomycin. There later followed extensive trials of the drug until its uses have become well delineated. It was recognized early that Neomycin was an effective drug but that when given intramuscularly, it had two areas of toxicity: (1) neurotoxic and (2) nephrotoxicity. Carr, Brown and Pfuetze[1], Kadison and Associates[5], and Powell and Hooker[10] reported eight patients who suffered hearing loss and 10 patients with renal function changes among a group of some 38 patients receiving parenteral Neomycin from two and one-half to six weeks. Since then, Neomycin has been used mainly as a topical agent or orally as an effective agent for the preoperative sterilization of the bowel. Since 1950, Poth[8] has had Neomycin under investigation as a therapeutic agent in the treatment of acute bacterial peritonitis and as an irrigant following open colon surgery. The method of use of this drug in three severe cases of peritonitis with gross fecal contamination is the subject of this paper.

There have been several reports concerning the effectiveness of intraperitoneal Neomycin in the treatment of acute bacterial peritonitis. Preliminary investigation of this particular use of Neomycin was carried out by Schatten and Abbott[14] who demonstrated that the antibiotic was markedly effective in controlling experimentally produced acute bacterial peritonitis and, furthermore, that the drug was relatively nonirritating to the peritoneal cavity.

Clinically, Prigot[12] and Associates used Neomycin in the treatment of 21 patients with peritonitis. Schatten[13] used the drug in 18 patients and Greene[3] studied the use of Neomycin in an additional 20 patients with peritonitis. There were no deaths in Prigot's series and the mortality rate in the combined group of Schatten's and Greene's was 18 per cent.

Respiratory suppression by neuro-muscular blocking agents

Despite the encouraging results of the use of Neomycin in treatment of peritonitis, a serious complication, respiratory depression, was encountered. In 1956, Pridgen[11], Engle and Denson[2] reported eight cases of respiratory arrest following the administration of intraperitoneal Neomycin. All eight cases had one thing in common: the dose injected into the peritoneal cavity at one time exceeded the .5 gram dosage recommended by the manufacturer.

Experimental work carried out by Pittinger, Long and Miller[7] in 1958 indicates that Neomycin in sufficient doses acts as a neuromuscular blocking agent. This paralysis is associated with respiratory depression and is potentiated in the presence of anesthetic concentrations of ether and is additive to the effects of succinylcholine.

The reversal of this apnea was described in a case report by Middleton[6] and his associates. However, this patient had also received succinylcholine which may have been responsible for the respiratory depression. In 1959, Jones[4] reported success in the treatment of the apnea by intravenous injection of calcium gluconate. Other observations demonstrated that the presence of the optimum concentration of calcium at the myoneural junction is essential from the effective release of acetylcholine after stimulation of a motor nerve. This effect is inhibited by magnesium. Unless effective amounts of acetylcholine are released, muscle contraction does not occur. Jones thought, therefore, that Neomycin might act by decreasing the amount of acetylcholine liberated at the myoneural junction, antagonizing the effect of calcium.

In view of the foregoing, it is apparent that although Neomycin is a most effective drug in the treatment of peritonitis it is also potentially dangerous if not properly used. Poth[9] has studied the use of Neomycin intraperitoneally and has used it successfully in several thousand peritoneal cavities without embarrassment to respiration except in one case, that of a day old infant.

Practical clinical use

Because of inherent dangers in the use of Neomycin, the following regime was adopted to guide in its use: (1) Only those patients with severe generalized peritonitis in whom a real danger of mortality is apparent should be considered candidates for the use of intraperitoneal Neomycin. (2) Following the definitive surgical procedure, the peritoneal cavity is carefully lavaged thoroughly with large amounts of warm normal saline. (3) Following the aspiration of as much of the saline solution as possible, a maximum of 200 c.c. of ½ of 1 per cent (½%) Neomycin solution is instilled into the peritoneal cavity and allowed to remain for a few minutes. (4) At least 100 c.c. of the Neomycin instilled into the peritoneal cavity is recovered by aspiration. (5) Multiple large drains are used through separate stab wounds, draining both subdiaphragmatic spaces, both lateral gutters, and the pelvis.

CASE REPORTS

P. C.: A 14-year-old white female was admitted to DePaul Hospital on August 23, 1959, from the scene of an automobile accident. X-rays indicated skull, facial and pelvic fractures. Althought there was no evidence of abdominal trauma, films of the abdomen were taken and read as negative. Eight hours later there was boardlike rigidity of the abdomen and free air was noted within the peritoneal cavity in a repeat flat plate. The patient was operated and a severe peritonitis encountered due to disruption of the mid-small bowel. Feces and about 1,000 c.c. blood were free in the peritoneal cavity. The small bowel rent, about eight inches in length, was sutured and the peritoneal cavity lavaged with saline. 250 c.c. of ½ per cent Neomycin solution was instilled and approximately 100 c.c. removed. Following this, multiple drains were placed within the peritoneal cavity and the wound closed. The patient made a completely uneventful recovery. Penicillin, Streptomycin, and Terramycin were used postoperatively. Fractures of the pelvis with the displacement of the right sacroiliac joints and avulsion of the skin of the right foot were later treated successfully.

G. N.: A 43-year-old white male was admitted to DePaul Hospital on March 11, 1960, from the scene of an auto accident. He had multiple bruises over his body including the abdomen. Roentgen studies indicated a fracture of the left 9th rib posteriorily but other x-rays including those of abdomen and chest were within normal limits. Laboratory work was within normal limits except for an initial leucocytosis of 19,900.

Two days later, however, the leucocyte count had dropped to 13,350 and the hemoglobin decreased from an admission level of 89 per cent to 77 per cent. On the fourth hospital day, the patient developed abdominal tenderness. At that time an IVP was being carried out and a minimal amount of air was noted beneath the diaphragm. A repeat study of the diaphragm was carried out several hours later and a huge accumulation of subdiaphragmatic air was found. The patient was operated the same evening and a severe generalized peritonitis with hemo-peritoneum in the amount of approximately 2,000 c.c. and gross fecal contamination resulted from an area of necrotic splenic flexure.

A thick adherent blood clot was found to trail from the splenic flexure on its medial aspect inferiorly to the pelvis. The origin of the hemorrhage was found to be a previously transected vessel of the splenic flexure. The mesenteric thrombosis neurosis of the colon resulted with multiple 1 cm. in diameter defects.

A splenic flexure colectomy with proximal and distal single barrel colostomies was carried out. Following this, blood and feces were cleared and the peritoneal cavity was lavaged with saline and finally an instillation of 250 c.c. ½ per cent of Neomycin solution. Eight drainage tubes were used.

The patient had an extremely stormy postoperative course but was able to leave the hospital three weeks later. No abdominal abscesses resulted.

C. L.: A 25-year-old white female was admitted to Memorial Hospital on November 11, 1959. The patient had multiple gunshot wounds of her head, neck, shoulders and hip with multiple disruptions of the soft tissues. The gunshot of the hip entered the peritoneal cavity and produced multiple perforations of the large and small bowel.

She was taken directly to the operating room and treated for shock and then operated. There was extensive fecal contamination as a result of 15 perforations of the small and large bowel and the presence of approximately 2,000 c.c. of blood within the peritoneal cavity. The peritoneal cavity was lavaged clear of blood and feces and the multiple perforations closed. The largest perforation was in the rectosigmoid area and, accordingly, the greatest amount of spillage was at this site. The multiple perforations along the mid-portion of the small bowel necessitated the performance of a side-to-side anastomosis. The peritoneal cavity was lavaged with warm saline solution and 200 c.c. of ½ per cent Neomycin. After allowing it to remain for about 10 minutes, half of it was recovered by aspiration. Multiple drains were then inserted.

Postoperatively, the patient was treated with Terramycin and experienced a good recovery. Approximately three weeks after operation, she developed a high spiking fever with a right sided, hard, tender rectal mass and this abscess ruptured spontaneously into the rectum with no further symptoms.

Summary and conclusions

The use of Neomycin intraperitoneally in three patients with markedly severe bacterial peritonitis with free blood and feces in the peritoneal cavity have certain common features: (1) they all lived; (2) none of the three developed a residual intraperitoneal abscess; (3) the recovery of each patient was rather prompt considering the seriousness of the illness; (4) the combination of thorough cleansing of the peritoneal cavity followed by the intraperitoneal administration of Neomycin was not complicated by an instance of respiratory depression when the dosage was held to 200 c.c. of ½ per cent solution administered and 100 c.c. recovered. •

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Glucosamine-potentiated tetracycline combined with triacetylated oleandomycin*

A clinical evaluation

Norman A. David, M.D., and Peter B. Carter, M.D., Portland, Oregon

This combination of drugs is an effective combatant particularly where there are polymicrobic infections or infections of unknown etiology.

THE PRESENT-DAY WIDE CLINICAL ACCEPTANCE of broad-spectrum antibiotic combinations for treating infections is understandable. Aware of the increase in the incidence of sensitivity reactions to penicillin, the likelihood of untoward effects being provoked by certain antibiotics and the fact that their usefulness is often limited by rapid development of bacterial resistance, the physician has become more critical in his selection of antibiotics. Current clinical interest in the broad-spectrum antibiotic combinations is supported by evidence that they may have a broader activity than a single agent when used for

*From the Department of Pharmacology, University of Oregon Medical School, Portland, Oregon. Cosa-Signemycin supplied by Pfizer Laboratories, Brooklyn, New York.

treatment in polymicrobic infections or for infections by unidentified organisms. Since potentiation of activity occurs when combinations are used, reduction in the dosage of the individual antibiotics is possible; this both lessens the incidence of untoward reactions and decreases the likelihood that resistant bacterial strains will emerge during therapy[1-5].

The present report deals with an investigation of the effectiveness of a combination of tetracycline (glucosamine potentiated) and oleandomycin (in the triacetyl form) in hospitalized and clinic patients.

Materials and methods

Fifty-nine patients, of whom 47 were adults, 10 were children and two were girls, both aged 14 years, were treated. In the group seen in the Pediatric Clinic there were five girls and five boys, including three infants from 8 to 10 months old, two children, both 2 years of age, and five others from 5 to 7 years of age. The average age of the 47 adults was 54.4 (range 18-80) years; in this group there were 31 men and 16 women, of whom 27 were hospitalized and 20 treated in the clinics. Types of infections treated are listed in Table 1. Bacteriologic cultures, as reported in Table 2, were obtained for three children, for the two teen-aged girls and for 38 adults. White blood cell and differential counts were made before and at the end of treatment on the majority of patients. Patients with pneumonia received serial chest x-rays, and prostatic smears and microscopic studies were made for patients with prostatitis.

Cosa-Signemycin®, a combination of tetracycline (167 mg.) potentiated with glucosamine (167 mg.) and triacetyloleandomycin (83 mg.) per capsule was administered to adults in doses of 250 mg. of the combined antibiotic given four times daily for an average of 6.3 days (range 2-14 days). The length

TABLE 1

Types of infections treated with tetracycline-oleandomycin combination

Infection (diagnosis)	Number of patients		
	Hospital	Clinic	Total
Pediatric group			
Otitis media		4	
Tonsillitis		3	
Upper respiratory infections		3	10
Adult group			
Dermatologic			
Cellulitis	2	1	
Thrombophlebitis (infection secondary to)	2		
Carcinoma, skin (infection secondary to)	2		7
Upper respiratory infections			
Pharyngitis	2	6	
Otitis media	2	3	
Bronchopneumonia	5		
Pneumonia, lobar	2	1	21
Urologic			
Cystitis	2	1	
Epididymitis	1	1	
Prostatitis		4	
Pyelonephritis	2		
Urethritis		2	13
Wound infections			
Postoperative	5		
Puncture, ulcer		2	
Traumatic	1		
	28	31	59

of treatment was governed by the fact that the patients seen in the clinics customarily returned at weekly intervals. Treatment in the hospitalized patients was continued, usually, for a shorter period and until it was evident that the combination had been effective or of little benefit. The two hospitalized 14-year-old girls, one of whom had a severe cellulitis of the toe due to streptococcus and who had active rheumatic fever, and the other who developed a secondary infection with cellulitis following a "cut-down" on the saphenous vein, with streptococcus cultured from the wound, were both treated with 250 mg. of Cosa-Signemycin given four times daily for six days. One 7-year-old girl in the pediatric group received the 250 mg. capsules four times a day for four days, while the other nine children were given doses of 125 mg. four times daily.

Results

The response to Cosa-Signemycin therapy by each patient has been classified as excellent when all signs and symptoms promptly disappeared, early evidence of healing was noted and the patient became afebrile within 24 to 36 hours. When a less dramatic but quite satisfactory result occurred with subjective and objective evidence of resolution of the infection within 36 to 72 hours, the response was considered good. The result was considered as "fair" when some beneficial response was obtained but objective evidence showed that the infection was not completely eradicated.

Three of the children had excellent responses, while five showed good results following trial of the tetracycline-oleandomycin combination. Failures were noted in an 8-months-old boy with acute pharyngitis due to beta streptococcus who was treated for seven days and the 7-year-old girl given 250 mg. of the combination four times a day for four days for a purulent otitis media.

The response was considered as excellent in 22 adult patients and the two 14-year-old girls (49.8 per cent) while a good result was obtained in 20 (40.8 per cent) adults. A "fair" response was noted in two adults, one of whom was treated for a prostatitis and chronic cystitis following a transurethral resection for carcinoma of the bladder and who had relief of symptoms but not a complete cure since 2+ pus continued to be found in his prostatic secretion. The other man came

TABLE 2

Bacteriologic diagnosis, antibiotic sensitivities of organisms and response to tetracycline-oleandomycin combination in three children and 40 adults

Bacteriologic diagnosis	*No. of cases	Antibiotic sensitivities (no. of cases)							Response (no. of cases)			
		Penicillin	Tetracycline	Chloramphenicol	Oxytetracycline	Oleandomycin	Erythromycin	Novobiocin	Excellent	Good	Fair	Poor
Staphylococci												
Hemolytic	5	1	..	1	1	1	..	..	3	1	..	1
Non-hemolytic	1	..	..	1	1	..	..	..	..	..	..	1
Staphylococcus aureaus	6	..	2	4	1	..	..	1	2	4	..	..
Streptococci												
Hemolytic	2	1	1	1	1	..	..	..	1	1	..	..
Beta streptococcus	8	5	4	1	1	..	..	..	6	1	..	2
Alpha streptococcus	3	..	..	1	1	..	..	..	2	..	..	1
Not specified	6	5	5	3	3	3	3	3	5	1	..	..
Proteus	2	..	..	2	..	..	..	..	..	..	..	2
Pseudomonas	1	..	1	1	..	..	..	1	1	..	..	..
Eschericha coli	3	..	2	1	1	2	..	..	1	1	1	..
Pneumococci	5	5	4	3	4	2	2	2	2	3	..	..
Streptococci fecalis	1	..	..	..	1	1	..	..	1	..	..	..
Aerobacter aerogenes	2	..	..	1	1	..	..	..	..	..	1	1

*More than one organism was found in the culture of three patients and in one patient no predominant organism was reported.

to the urology clinic for treatment of an acute exacerbation of chronic prostatitis; he felt much better after taking the antibiotic combination for seven days, but still showed 3+ pus in his prostatic fluid.

Three adults failed to show improvement to therapy. One was a man, aged 71 years, who had an acute epididymitis four days after a transurethral resection of the prostate with nonhemolytic staphylococci and alpha streptococcus cultured from the prostatic secretion and aerobacter aerogenes, sensitive only to chloramphenicol and oxytetracycline, found in the urine. Following treatment for seven days, there was some reduced swelling of the scrotum but the testes were still tender and 4+ pus continued in the urine. The second patient was a man aged 65 years who was hospitalized for a hemorrhagic cystitis and prostatic carcinoma. Proteus vulgaris, sensitive only to chloramphenicol, was cultured from the urine. Since no response was noted after two days of treatment, chloramphenicol therapy was instituted with a subsequent good response. The third patient, a woman aged 37 years who had pyelonephritis following cystoscopy, also harbored proteus vulgaris in the urine. Again, this microorganism was sensitive only to chloramphenicol. After three days' trial of the tetracycline-oleandomycin combination, she was transferred to treatment with chloramphenicol with clearing of the infection in two days.

Side effects were seen in only two patients. A boy, aged 2 years, with tonsillitis developed a generalized red, mottled rash on his face and trunk on the fourth day of treatment. Since his tonsillitis had cleared, the antibiotic was stopped and the rash promptly disappeared. A man, aged 48 years, who was treated for an abscess and wound infection developing postoperatively, had a moderately severe diarrhea on the fourth day of therapy. Since his infection showed good improvement, further treatment was stopped and paregoric prescribed for the diarrhea.

Discussion and conclusions

The inconvenience and time lag involved in procuring antibiotic sensitivity determinations pose a severe problem for the practicing physician. On housecalls and in the office, prompt therapy is necessary. The patient cannot go without therapy for the day or two needed to isolate, identify and test the pathogenic organism for antibiotic sensitivity. In this evaluation, for instance, although it was conducted under hospital conditions, before reports could be obtained from the laboratory most patients had already responded to the tetracycline-oleandomycin preparation and in many cases were afebrile and symptom free.

Of the many possible combinations, one of the more useful would appear to be the combination of the tetracycline and oleandomycin[6-8]. Extensive clinical experience with tetracycline has established its broad spectrum efficacy against a variety of infections caused by gram-positive and gram-negative bacteria, rickettsiae, large viruses and certain protozoa. Oleandomycin supplements the spectrum of tetracycline activity. It is effective against gram-positive bacteria (including streptococci, pneumococci and some strains of staphylococci resistant to erythromycin, penicillin, and the tetracyclines) and several species of gram-negative bacteria. Most strains of staphylococci do not demonstrate cross-resistance between oleandomycin and tetracycline in vitro.

The preparation evaluated in this study is doubly useful in that both the tetracycline and oleandomycin are in a form which provides potentiated absorption: the tetracycline by the addition of glucosamine[9-11] and the oleandomycin through triacetylation[12-14].

Summary

Fifty-nine patients with respiratory, urogenital or soft-tissue infections were treated with a combination of glucosamine-potentiated tetracycline and triacetyloleandomycin. Eight of the 10 children and 44 of the 49 adults treated had satisfactory responses. They became afebrile promptly and all signs and symptoms of infection resolved, often within 24 to 48 hours. Only two patients had mild untoward responses: a boy who developed a rash which disappeared spontaneously when therapy was stopped and a man who had a diarrhea.

The combination of tetracycline and oleandomycin is an effective one, and may be an antibiotic combination of choice in treating patients for polymicrobic infections or infections of unknown etiology.

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The mystery of the swimming pool*

Roy L. Cleere, M.D., Cecil S. Mollohan, M.D., Denver, and Mary S. Romer, R.N., Atlanta, Georgia

A new disease, brought into prominence by a classic epidemiologic investigation of one of Colorado's touted tourist attractions, is here thoroughly discussed and illustrated. Other areas with mineral water pools would do well to take a similar close look at suspicious granulomatous skin lesions among their pool users.

THE TITLE OF THIS PAPER is given as "The Mystery of the Swimming Pool" but more appropriately it should be "the solution of the mystery." The solution has come through the application of the principles of epidemiology which we are inclined to overlook in this day of "miracle drugs" when we are concerned more with treatment and often forget to find the cause. In the traditional "who-dun-it" technic, circumstantial evidence would be discussed, the laboratory findings reported, the inferences and the hypotheses presented but not until the last page of this paper would the real culprit be revealed. Apparently enough people have read the last page that we can get into the case at this point.

We were aware that we had a "corpus delicti" when Dr. John Hyland of Grand Junction informed the Mesa County Health Department that he had been treating several cases of lesions of the elbow, which he had diagnosed as "swimming pool granuloma," reportedly acquired shortly after swimming in the Glenwood Springs pool. This information was conveyed to the State Health Department and reached this office at the same time Dr. Robert Lewis of Glenwood Springs reported the same information.

Preliminary investigation

Miss Mary Romer, a nurse epidemiologist assigned to the Department by the Public Health Service, visited Glenwood Springs on a preliminary investigation. Information obtained at this time indicated there were more cases than suspected — physicians, public health nurses and parents reported 40 cases. All cases were school age children. There was also community acceptance that "sore elbow," as it was called locally, was "something one got from the pool." Schools had closed for the summer, making intensive case finding impractical at the time.

During the summer months, investigations of clinical aspects of the cases and public health engineering and laboratory studies of the pool were made. The National Jewish Hospital at Denver undertook pathologic and bacteriologic studies of lesions obtained by punch biopsy of cases and performed bacteriologic studies on water and silt samples taken from the pool. The latter part of this paper will present detailed information and illustrations of the clinical and laboratory findings so we will not dwell on those points at this time. However, the laboratory studies confirmed the infections to be due to Mycobacterium balnei and the same organism was obtained in almost "pure culture" from the pool. The literature reports a similar disease entity caused by Mycobacterium balnei in pools in Sweden but in fewer numbers of cases than apparently were

*Presented at the Midwinter Clinical Session of the Colorado State Medical Society, February 18, 1960. Roy L. Cleere, M.D., is Director, Colorado State Department of Public Health, Denver; Cecil S. Mollohan, M.D., is Chief, Epidemiology and Tuberculosis Control, Colorado State Department of Public Health, Denver; and Mary S. Romer, R.N., is Nursing Consultant, Communicable Disease Center, Public Health Service, Atlanta, Ga.

involved in the Glenwood Springs outbreak.

At the start of school in September, 1959, further case finding was instituted. A leaflet had been prepared giving parents, teachers and pupils information on the nature of the outbreak. A bulletin was posted in the junior and senior high schools in Glenwood Springs directing pupils to report to the school or public health nurses if they had or had had "sore elbows" or similar lesions on other parts of the body. An additional 84 cases were found through this method of case finding.

Positive tuberculin tests

The Swedish literature had indicated that M. balnei infections had converted tuberculin tests from negative to positive and it was decided to test this as a possible case-finding procedure. There had been routine tuberculin patch testing programs in the Garfield County schools in 1957 and 1958 and information was available on the test status of most of the children. Seventy-one pupils with known skin lesions were tested with the Vollmer patch test—with a resulting 85 per cent positive reaction. Of the positive reactors, 91 per cent had converted since their tests of the previous one- or two-year interval.

Mass tuberculin patch testing was done on pupils in selected grades and the junior and senior high schools. The total number of positive reactors was far greater than would normally be expected in children in which the tuberculosis rate in the community was low (charts later). Inspection and interrogation was done by public health nurses on all positive reactors to determine if there were unidentified or forgotten lesions. A characteristic scar was accepted as a case.

We have now concluded our organized case-finding activities and have a total of 262 persons who now have or have had, during the past several months to seven years, the typical granulomatous lesions of the skin—all of whom report onset of the infection within two to four weeks of swimming in the Glenwood Springs pool. Undoubtedly there are many more cases but we feel nothing would be added to our present knowledge to spend more time in further case-finding procedures.

Glenwood Springs pool

As many of you know, the Glenwood Springs pool is famous as a warm mineral water pool. Hot water from mineral springs was cooled with water from the tail race of the power plant to approximately 82°-85° F. It was not possible to obtain a chlorine residual in this water as reaction of the chlorine with the minerals formed a precipitate which bound the chlorine in chemical combination and in addition caused turbidity which obscured the bottom of the pool. The walls of the pool were of rough field stone which were exposed above the water level and were covered with a thin coating of rough concrete below the water line. A rope on which swimmers supported themselves extended around the pool a short distance above the water line. The elbow was the site of the lesion in 85 per cent of the reported cases and it seems safe to assume the abrasions were received from the rough wall as the swimmer held on the rope. The pool was of a "draw-and-fill" operation in which the pool was emptied one day each week, scrubbed and hosed and then refilled, after which there was a continuous flow of water through the pool. However, due to the rough surface of the walls and the many crevices in and between the stone, it was not possible to drain completely all water even when it was assumed to be empty. When the pool was under suspicion in early summer, the operators tried various means to disinfect the pool more adequately, including scrubbing with chlorine solution and using chlorine solution in pressure hoses; but a few days after refilling, Mycobacterium balnei could again be isolated from water samples. On January 4 of this year, the operators voluntarily closed the pool for complete remodeling and redesigning. The State Department of Public Health will give all other warm mineral water pools in Colorado very careful checks when they reopen for seasonal operation in the spring to be sure similar conditions do not exist.

One other point needs mentioning. It has been mentioned that tuberculin tests showed positive reactions even though the apparent causative organism was Mycobacterium balnei. This leads to speculation as to the

limitation of the tuberculin test as a tuberculosis case-finding tool. More investigation will be needed before all implications of this point are clarified.

Clinical and laboratory findings

The typical case began as a small reddish papule usually on the elbow but occasionally on the knee, foot, finger or leg (Fig. 1). In seven cases the lesions appeared on both elbows simultaneously. The lesions appeared about three weeks after swimming in the pool. In the course of about two weeks, the lesion grew to the size of a pea and became hardened and purplish-red in color. Some opened and drained slightly at this stage. They then became covered by brownish crusts or scales under which was a shallow ulceration containing a small amount of greyish secretion (Fig. 2). Satellite lesions surrounding the original were not uncommon.

Laboratory investigations in this outbreak were done under the direction of Dr. W. B. Schaefer and Dr. Charles L. Davis at the National Jewish Hospital at Denver. Fifteen biopsy specimens were cultured on oleic acid-albumin agar and colonies of acid-fast bacilli were obtained in 8-12 days of incubation at 30° C, the colonies being white on removal from the incubator and turning yellow, then orange when exposed to daylight. They were larger, both longer and wider than tubercle bacilli, otherwise closely resembled them in appearance. Based on the characteristic of a very limited temperature range for incubation, the variation in size compared to the tubercle bacillus and the distinctive transverse banding of the organism, it was determined to be Mycobacterium balnei (Fig. 3).

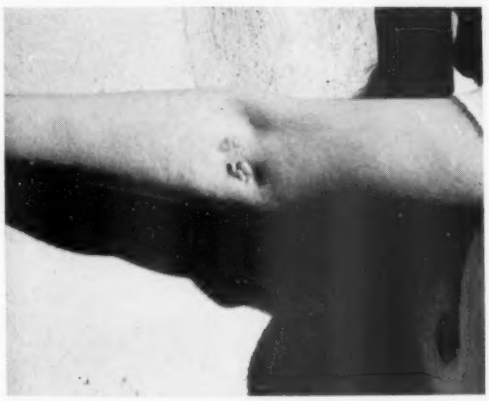

Fig. 1. Granulomatous lesion on elbow of six months duration showing characteristic spongy granulation with some satellite lesions.

Summary

A total of 262 cases of granulomatous lesions of the skin have been reported following swimming in the Glenwood Springs pool. Laboratory findings on biopsy tissue and water from the pool indicate Mycobacterium balnei as the causative organism. The elbow was the site of 85 per cent of the lesions. Eighty-six per cent of reported cases were between 10 and 19 years of age.

Tuberculin testing (Vollmer patch test) was done on 1,648 children in the community. Among those with no skin infections there

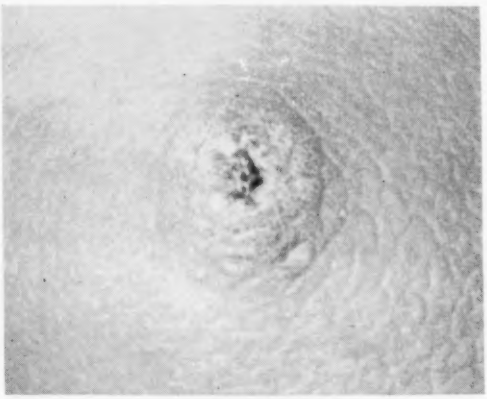

Fig. 2. Typical granulomatous lesion of approximately three months duration. Typical crater formation is visible in the center.

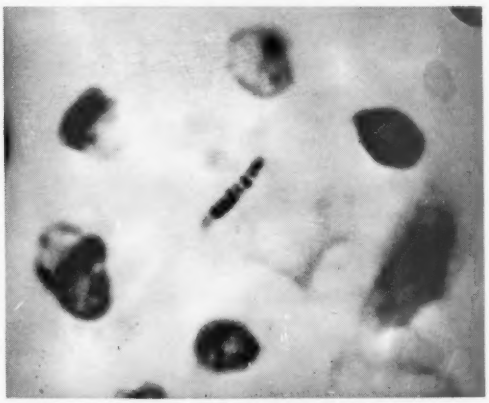

Fig. 3. Mycobacterium balnei showing distinctive transverse banding. Magnified 2,000 times.

was a total positive test rate of 4.3 per cent compared to a rate of 82 per cent for those with lesions.

Of 185 persons with granulomatous lesions patch tested, 151 (82 per cent) showed positive tuberculin reactions—77 per cent of these having converted since their last previous patch test done one or two years prior to the development of their skin lesions. Chest x-rays done on all positive reactors and granuloma cases showed no pathology suggestive of tuberculosis. •

Simultaneous retropubic prostatectomy and inguinal herniorrhaphy*

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These two frequently associated lesions may be repaired successfully in a one stage operation.

INGUINAL HERNIA IS THE MOST COMMON surgical lesion associated with urinary obstruction due to prostatism. In 1949 McDonald and Huggins, in an article entitled, "Simultaneous Prostatectomy and Inguinal Herniorrhaphy" noted a 15 per cent incidence of inguinal hernias in 100 consecutive cases of prostatic hypertrophy. To my knowledge, they were the first to advocate the simultaneous operations.

Background

In 1948, I performed my first hernia repair in conjunction with a suprapubic prostatectomy. After performing the prostatectomy, I had proceeded to do an orchidectomy for a large thick-walled hydrocele and discovered an unsuspected inguinal hernia. I proceeded to repair the hernia and the patient made an uneventful recovery. This case was one of a series of 30 suprapubic prostatectomies, which I reported in 1950. In this series of 30 there were three hernia repairs, the one already mentioned, another performed later during the same period of hospitalization and another done later at a separate hospitalization. The idea of purposely performing the simultaneous prostatectomy and herniorrhaphy thus had presented itself. By 1950 when I reported my first 47 cases of retropubic prostatectomy, I had done six simultaneous herniorrhaphies with no complications. By this time I was convinced that this was a practical procedure, which could relieve the patient of two distressing lesions without increasing the risk to the patient or prolonging his hospitalization. Thus two separate operations, two anesthetics, and prolonged and separate hospitalizations were avoided with its attendant emotional and financial trauma.

There seemed to be no reason why the same surgeon should not perform the simultaneous operations, or to have the referring surgeon perform it, if he were present. I have become an enthusiastic advocate of the procedure. In a review of 309 retropubic prostatectomies, 66 inguinal hernia repairs have been performed.

Technic

Retropubic prostatectomy, when performed through a transverse lower abdominal incision, affords easy access to the

*Presented at the 25th Annual Midwinter Clinical Session of the Colorado State Medical Society, February 19, 1960, Denver.

inguinal region by lateral extension or retraction. The absence of urinary drainage in this operation minimizes wound contamination. In only one case was wound infection an annoying factor which did not affect the hernia repair. Prostatectomy is performed first and then, if the time elapsed is not too great and the condition of the patient warrants, the hernia is repaired. If it is bilateral, I repair the larger or most symptomatic one. On occasion, bilateral repairs have been done but it has been in these cases that there have been the most recurrences, so I no longer do bilateral repairs, especially if the hernias are of the direct type. McDonald and Huggins repaired the hernia first, through a separate incision, that was sealed off from the prostatectomy incision, which was made later.

Hernia repair has been done by various technics, but mainly following the principles of McVey. After taking care of the hernial sac in the usual manner, the transversalis fascia is approximated to Cooper's ligament and the ramus of the pubis is approximated lateral-ward to the femoral vein. In other cases, approximating the conjoined tendon and the inguinal ligament was more feasible. In a few cases of direct hernia, the transversalis fascia has been approximated to the ramus of the pubis from the posterior approach before closing the prostatic incision.

In a patient past 50 presenting himself for hernia repair, it is important to be sure that this patient does not also have associated prostatism, which possibly may be an etiologic factor in the hernia. The prostatic obstruction should be cared for first and then the hernia. You can now choose simultaneous correction. This will save one the embarrassing situation of having repaired a hernia, only to have the patient develop urinary retention which necessitates prostatectomy.

From June, 1948, to date, I have had 309 patients with prostatism who have undergone retropubic prostatectomy. Sixty-eight, or 22.3 per cent, had inguinal hernias and of these, 58 had herniorrhaphies at the time of prostatectomy. Fifty were unilateral repairs and eight were bilateral. Ten patients had unilateral inguinal hernias that were not repaired and five had bilateral hernias with unilateral repair.

Types of hernias and results

Thirteen patients had bilateral inguinal hernias. Of these, five had unilateral repairs and eight had bilateral repairs. Of the eight cases, two were bilateral direct, two bilateral indirect, two combined right direct and indirect and two left direct with combined right direct and indirect. Of these eight cases, there were three recurrences, one a bilateral and the other two a recurrence on the right. One of these cases of unilateral recurrence was asmyptomatic and the other developed to distressing proportions. The bilateral recurrence sought another surgical repair elsewhere.

The 50 unilateral inguinal hernias consisted of 20 direct and 30 indirect. Of the direct group, 17 were right-sided and three left-sided and five of the total also had associated indirect hernias.

Of the indirect group of 30, 22 were on the right and eight on the left and one had an associated femoral hernia. Four of the hernias were recurrent at the time repaired. There have been three recurrences since repair in this group of 50, or 6 per cent from this group compared to four recurrent hernias in 16 repairs done in the eight bilateral cases, or 25 per cent. There were a total of seven repairs that recurred. Three of these were indirect inguinal hernias, one was direct and three were combined direct and indirect.

Follow-up

It is interesting to note that, from my follow-up, 10 of the 251 patients who did not have inguinal hernias at the time of prostatectomy, have since developed an inguinal hernia. Because follow-up is not perfect, the number is probably greater. Most of these developed about one year postprostatectomy.

In the entire series, there was one death resulting from pulmonary embolism. This occurred the day the patient was to be dismissed from the hospital, following an evacuation of his bowels. Postmortem examination revealed that the veins adjacent to the hernia repair were not the source of the embolis, so this case of embolism could not be directly attributed to the trauma of the hernia repair.

In addition to the hernias already

described, umbilical hernias were repaired simultaneously three times in this series and on one occasion an inguinal herniorrhaphy was performed at the time of a transurethral prostatic resection.

Summary and conclusion

In a series of 309 prostatectomies, inguinal hernias were present in 68 cases or 22.3 per cent. This indicates that inguinal hernias are the most common surgical lesion associated with prostatism. Fifty-eight of the 68 patients had herniorrhaphies performed at the time of prostatectomy. This has proven to be a satisfactory procedure, except in the cases where bilateral herniorrhaphy was performed. Because the incidence of recurrence in bilateral repairs was 25 per cent as compared with 6 per cent in the unilateral repairs, I now practice unilateral herniorrhaphies in the bilateral cases.

Patients past 50 years of age presenting themselves with an inguinal hernia problem should be studied with care to be sure they do not have associated prostatic obstruction which will lead to urinary retention, infection and a prostatectomy that was not foreseen. It is in this group, especially, that the combined operation will save the surgeon embarrassment and the patient an unexpected operation.

Retropubic prostatectomy lends itself especially well to simultaneous hernia repair, since through a transverse incision with lateral extension or retraction, the time involved in performing a hernia repair is minimal and the patient is thus saved two separate surgical procedures. •

The management of injuries of major arteries

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Report of three cases demonstrates valuable experience in primary management and in the use and fate of vein and plastic grafts.

RECENT EXPERIENCE with three cases of trauma to major peripheral arteries has prompted our review of current thinking and practice in the management of vascular injuries. Each case, although not unusual, presented special surgical problems which are being encountered with increasing frequency.

CASE REPORTS

Case 1: A 35-year-old white male laborer accidentally shot himself in the right leg while sitting in a truck. The .22 caliber bullet was fired from a pistol and entered the patient's right thigh laterally in the middle third and lodged and fragmented posterior to the lower femur. Following the injury, he was given emergency care and supportive treatment on another service. He was hospitalized initially for two weeks during which time there was apparently considerable swelling of the right lower leg. This subsided gradually on a regimen of rest and elevation. He was dismissed from the hospital only to be readmitted in one week with swelling and tenderness in the right calf and symptoms, signs, and x-ray findings compatible with the diagnosis of left pulmonary embolism. He was hospitalized 10 more days at this time and was given anticoagulants. Following his second hospitalization there was considerable aching in the right calf and right popliteal area, mainly at night. There was no real claudication, but the patient was definitely disabled and unable to work.

In December, 1958, two months following the

original injury, the patient was referred for repair of a right popliteal arteriovenous fistula. On examination he appeared well. The blood pressure was 138/90 mm Hg and the pulse rate was 90/minute. The heart was of normal size, rhythm was regular, and no murmurs were heard. The lungs were clear. The abdomen was tender Grade I in the right upper quadrant where the liver edge was just palpable. Deep tendon reflexes were equal and active. There was a lime-sized pulsating mass with a continuous murmur and bruit in the right popliteal fossa. The superficial veins were dilated in the right anterior tibial area, but there was no edema or palpable increase in skin temperature. Pedal pulses were normal bilaterally. Results of routine laboratory studies were within the limits of normal. Hemoglobin was 15.5 gms per 100 cc. and the hematocrit was 48 per cent. Chest x-ray was essentially negative, and there was no cardiac enlargement. An electrocardiogram was not made.

On December 30, 1958, under general anesthesia with tracheal intubation, exploration of the right popliteal vessels was carried out through an S-shaped posterior incision. There was a false aneurysm and an arteriovenous fistula involving such a large portion of the popliteal vein that sacrifice of the latter was necessary. The fistula and the large aneurysmal sac were excised. The ends of the popliteal vein were ligated. A 4.5 centimeter defect in the popliteal artery was bridged with a preclotted, knitted teflon prosthesis anastomosed to the artery at each end with continuous over-and-over sutures of 5-0 arterial silk interrupted at the angles. After removal of the clamps the graft functioned satisfactorily, and the incision was closed in layers without drainage. At the conclusion of the procedure the pedal pulses were normal. Postoperatively there was some transient tenderness in the left calf and left ilio-femoral area. In view of the past history of venous thrombosis and pulmonary embolism, this was treated with anticoagulants. The patient was dismissed on the fourteenth postoperative day and has been seen as an out-patient several times during the succeeding year. The arterial graft continues to function satisfactorily, and there is no disability. There are some signs of venous insufficiency in the right lower extremity below the knee, including dilated veins and occasional transient swelling, but these appear to be improving gradually.

Case 2: An 18-year-old white female was admitted to the hospital at 3 a.m. on January 11, 1959, after having been involved in an automobile accident. She was fully conscious and alert and the blood pressure was 130/80 mm Hg, and the pulse rate was 120/minute. Examination of the heart and lungs was negative. There was an extensive, compound, comminuted fracture of the upper third of the left humerus. The laceration of the left upper arm was almost completely circumferential, and the distal extremity was cold, cyanotic and pulseless. There was a comminuted fracture of the left radius and a fracture of the styloid process of the ulna. There appeared to be loss of median and ulnar nerve function, but the radial nerve functions were intact. In addition, there was an extensive laceration of the right leg. The hemoglobin was 11.8 gms per 100 cc. The hematocrit was 37 per cent.

In the operating room under general anesthesia, further exploration of the wounds revealed an extensive laceration and avulsion of the musculature around the left humerus. The median, ulnar, and radial nerves were anatomically intact. A segment of the brachial artery approximately 2.5 centimeters long was severely contused and in spasm. There was a large subadventitial hematoma in this portion of the vessel, and no pulsation was detectable in the artery distally or at the wrist. Attempts to restore the pulse in the brachial artery were of no avail, including warm compresses, excision of the adventitial tissues, injection of procaine and, finally, excision of the injured segment and ligation of the ends of the artery. A prosthesis of proper size was not available to bridge the defect in the relatively small brachial artery. Accordingly, a 4.0 centimeter segment of autogenous saphenous vein was obtained from the left groin and interposed between the severed ends of the artery. The graft was placed so that the valves opened in the direction of blood flow and anastomosed at each end with a continuous suture of 5-0 arterial silk interrupted at the angles. Following removal of the arterial clamps, there was good transmission of the pulse into the brachial artery distal to the graft and minimal bleeding from the anastomoses. Thorough debridement and irrigation of the wound was carried out, removing multiple fragments of bone and all detectable nonviable muscle. An Egger's plate was inserted for fixation of the fractured humerus, and the muscle and subcutaneous tissues closed loosely about the metal plate and the vein graft. The remainder of the wound was packed loosely with gauze. Finally the fractured radius was manipulated and the entire extremity immobilized in a long arm cast. The laceration in the right leg was cleansed, debrided, and sutured. During the procedure the patient was given a transfusion of one unit of whole blood.

Postoperatively parenteral penicillin and streptomycin were administered. On January 29, secondary closure of the wound was carried out. The metal plate and screws were removed at this time because of the fear that a sinus tract was developing in the area. The patient was afebrile, and the secondary closure had healed satisfactorily at the time of hospital dismissal on February 7, 1959. There was a good radial pulse and normal radial nerve function at this time, although there continued to be considerable impairment of ulnar

and median nerve function. The latter, however, improved greatly during the course of vigorous physiotherapy, and on July 16, 1959, she was readmitted to the hospital for bone graft of the left humerus which had healed by fibrous union. Recovery from the latter operation was uncomplicated, she continues to have normal circulation in the extremity, and the functional result is satisfactory and still improving.

Case 3: A 30-year-old white male laborer was admitted to the hospital December 1, 1958, after having sustained a gunshot wound in a hunting accident. The major portion of a 12-gauge charge of No. 6 CH shot had entered the upper third of the right arm from close range. The wound of exit was located at the posterosuperior aspect of the right shoulder. He was in only fair general condition at the time of admission, the blood pressure being 90/70 mm. Hg and the pulse rate 110/minute. Examination of the heart and lungs was negative. The right arm and hand were cold and pulseless and the radial nerve was paralyzed, but median and ulnar nerve function was normal. An x-ray showed an extensively comminuted fracture of the upper half of the right humerus with many lead shot in the area. The patient was told that amputation would probably be necessary, and he was taken to the operating room.

A transfusion of whole blood was started, and general anesthesia with pentothal sodium, nitrous oxide and oxygen was begun. The anterior wound of entrance was enlarged and cleansing and debridement carried out. The proximal portion of the brachial artery was found to be severely contused. A segment of artery approximately 4.0 centimeters long contained an extensive subadventitial hematoma, and the pulse was not transmitted distally in the vessel. Further dissection revealed the three major nerve trunks to be anatomically intact although the radial nerve was slightly contused. It seemed at this point that an attempt to save the arm was justifiable and indeed indicated. Accordingly, the injured segment of brachial artery was excised between arterial clamps and vessel continuity was reestablished with a preclotted, knitted, teflon prosthesis which was anastomosed at each end with a continuous suture of 5-0 silk interrupted at the angles. Upon removal of the clamps there was considerable bleeding for a time from the interstices of the graft, but this was eventually controlled with pressure and by partially covering the graft with gelfoam strips. When the graft was functioning well and this portion of the wound was dry, further debridement and irrigation of both the anterior and posterior wounds was carried out. Numerous bone fragments and lead shot were removed, and large quantities of nonviable muscle were excised. The arterial graft was covered with muscle and subcutaneous tissue. The remainder of the anterior wound and the posterior wound were loosely packed with gauze and a posterior drain inserted. At the conclusion of the procedure, there was a good radial pulse. The patient had received eight units of whole blood before and during the operation. The extremity was dressed and bound securely to his side in order to minimize motion of the loose bone fragments. Penicillin and streptomycin were administered parenterally, and on December 10, nine days following the original surgery, the wounds were further debrided and closed secondarily with drainage of the subcutaneous tissues. At this time median and ulnar nerve function was intact and the radial pulse was normal. There was complete radial nerve paralysis. Five days later there was evidence of superficial infection in the wounds which were reopened widely. Local treatment of the wounds was continued on an out-patient basis until January 5, 1959, when the patient was readmitted because of increasing pain in the upper right arm and purulent drainage from the anterior wound. The arm had previously been placed in a windowed cast, and the pain and drainage responded somewhat to the administration of penicillin and streptomycin. However, on January 13, exploration under general anesthesia revealed a sinus tract in the anterior wound leading into the region of the arterial graft. More sequestered bone fragments were removed, and the sinus tract loosely packed. Cultures were reported to show staphylococcus albus sensitive to novobiacin. The patient was dismissed on the following day and advised to take novobiacin by mouth. The radial pulse remained normal, and the median and ulnar nerve functions were intact. Soon after this the patient was transferred to another hospital where amputation became necessary because of hemorrhage from the infected sinus tract.

Discussion

Modern principles of management of acute vascular injuries have been developed in the years following World War II and the Korean War. During the former conflict, ligation of injured vessels was the accepted method of treatment, and the amputation rate was 50 per cent in wounds involving a major artery[1]. In the Korean War the amputation rate in similar injuries was reduced to approximately 17 per cent[3]. Many factors were responsible for this improvement, but undoubtedly the most important was the effort made by the Army vascular surgery teams in Korea to repair all major arterial injuries either by lateral arteriorrhaphy, end-to-end anastomosis, or by graft. The rationale of primary repair of arterial wounds is equally applicable in civilian practice.

Our use of a plastic (teflon) arterial graft in a contaminated wound (Case 3) might be justifiably questioned. However, the recent work of Schramel and Creech[6] indicates that synthetic arterial grafts function quite well in the presence of infection and/or exposure, and for this reason may be of more value in the surgery of trauma than autogenous or homologous vessels. On the other hand, the success of autogenous vein grafts in many of the Korean War wounds, in our Case 2 and in many similar civilian injuries is evidence that the method is satisfactory. The use of a synthetic prosthesis in Case 3 was on a somewhat arbitrary basis. A teflon graft of suitable size was readily available, and less time was required for its insertion than would have been necessary to properly obtain and insert an autogenous vein graft. The exact fate of the teflon prosthesis in this case is unknown to us, since we did not have the privilege of following the patient after he developed a draining sinus. The latter complication was apparently not a significant one in the series of arterial injuries treated either by direct anastomosis or autogenous vein graft during the Korean War. Late hemorrhage from the suture line was also rarely encountered. However, latent thrombosis of a vein graft does occur, apparently more frequently than is generally realized. Foster, Berzins, and Scott[2] demonstrated experimentally the superiority of nylon prostheses over homografts in the maintenance of aortic continuity in the presence of frank infection. This is a somewhat different problem than arterial replacement in a wound which is merely contaminated, but it does demonstrate the resistance of synthetic grafts to disruption and thrombosis. It should be noted, however, that disruption has been reported with synthetic grafts[5, 6] when infection involves the anastomotic suture line. There is one further point which may be of importance in regard to the use of synthetic prostheses in acute vascular trauma. It is probably true that the longer a graft functions, the better are the chances of limb survival even though removal of the prosthesis eventually becomes necessary either due to persistent infection or hemorrhage.

It is apparent that the place of synthetic prostheses in the repair of acute injuries of major arteries has not as yet been clearly delineated. More experience must be accumulated with regard to this particular phase of the problem. The important established principle in the management of this type of trauma, however, is that repair of the artery should be attempted if there appears to be any chance of obtaining a useful limb and if the patient's general condition permits. A very small tear in the vessel may be safely closed by primary suture, but larger injuries should be excised adequately and vessel continuity re-established either by end-to-end anastomosis or by graft. The repaired artery should be covered, but most of the wound must be left open for secondary closure in all cases where there is a significant amount of contamination or destruction of tissue.

There appears now to be general agreement concerning the proper management of arteriovenous fistulas. In a study of 134 traumatic arteriovenous fistulas and aneurysms of major vessels, Hughes and Jahnke[4] reported the best results in those cases treated by reconstruction of the vessels rather than by obliterative procedures. These authors stressed the importance of preserving the vein in order to prevent the distressing symptoms of chronic venous insufficiency. In our case, the popliteal vein had been damaged so severely that its preservation was impossible. Fortunately, the patient did not develop significant symptoms of venous insufficiency.

Summary

In conclusion, three cases of trauma to major arteries have been presented. A number of principles involved in their management have been discussed. •

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Organization and functions of industrial health departments*

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Growth of industrial health departments has been greatest during the last decade. Safety has proved to be good business.

SAFETY FIRST

SINCE THE EARLY 1900's, when Workmen's Compensation Acts were enacted, there has been a great increase in company medical programs. The original purpose of most plans was to reduce compensation costs by early recognition and treatment of job-related illnesses and injuries. During the past 50 years, these programs have increased in numbers and their scope has been considerably broadened. Comprehensive programs now attempt to give advice in correct job placement and then to guard the physical and mental health of employees by health maintenance progress.

There are a number of forces behind this growth of employee health plans:

1. The number of older employees is increasing as the population ages. This leads to greater absenteeism from chronic health problems and perhaps greater susceptibility to new occupational health hazards.

2. Labor has succeeded in obtaining medical insurance programs as fringe benefits in collective bargaining. Many companies, therefore, have considered it good business to finance a health maintenance program to detect and treat illness before it becoms disabling rather than to bear the heavy insurance costs of prolonged medical care later on.

3. The competition for executives and skilled labor continues to increase as the relative supply diminishes. Companies, therefore, are most anxious to keep those that they have working at the best possible efficiency.

4. Periodic health examinations for executives have brought startling discoveries of unsuspected disabilifies. The salvage of many valuable people has led management to think in terms of health maintenance examination programs for all employees.

5. Technicological progress, particularly in the chemical and radiant energy fields, has led to new health hazards.

6. Most companies that have operated successful health programs are convinced of the social and economic rewards. Such convincing evidence is important in influencing more and more companies to initiate such programs.

As these forces continue to stimulate growth of industrial health plans, consultation with persons trained in medicine and some experience in industrial health becomes more and more necessary. The number of physicians formally trained in industrial medicine is nowhere near the numbers required nor will training programs be able to produce an adequate supply in the foreseeable future. We private practitioners, with an interest in industrial problems, will be expected to consult with industry concerning many or all of these problems.

Company policy

A knowledge of the scope of the problems precedes recommendations as to development of a company health policy or implementation of a policy if such already exists.

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This policy or philosophy is agreed to or decreed by management. Policy, therefore, determines the actual function of an industrial health program. The breadth of such functions, to a great extent, should influence the shaping of the actual mechanics or organization of an industrial health department.

A few of us may be asked to consult in the formation of an original plan for an industrial program. Much more commonly, we will be called upon to participate in programs that have already been established. Although they may be local in the Rocky Mountain area, they will more likely be branch plants whose policy and organization are directed from a distant executive office. There is a great variety of organizations and functions in this field and it is worthwhile to review some of the important aspects of these.

A recent report by the National Industrial Conference Board titled, "Company Medical and Health Programs," analyses the programs of 278 cooperating companies. Most companies have a written policy which answers two basic questions: "What is to be accomplished?" and, "Why do we want to accomplish it?" Such a written policy is invaluable to the medical director who then tailors his program to implement the policy.

Department functions

Depending on the philosophy of management, their policy may require the medical department to set up a broad program that is all-inclusive or it may be that only first aid and referral services for on-the-job injuries are required. Thus, the function of the department may include any or all parts of the following services:

1. Pre-employment examination.
2. Job placement advisory service.
3. Treatment of on-the-job injuries or illness related to occupational disease.
4. Treatment of nonoccupational injuries or illness *occurring while on the job.*
5. Treatment of any injury or illness, regardless of cause or site of occurrence.
6. Control of communicable disease and prophylactic immunization.
7. Periodic voluntary health examinations.
8. Instruction in safety and personal health.
9. Consultation regarding factors causing maladjustment, personal or work-incurred.
10. Return-to-work examinations.
11. Periodic examination for detection of signs of exposure to special hazards.
12. Service for retired employees.

Department organization

Depending upon the scope of functions of the department, the services may be conducted by a referring nurse or first aid team, a full-time physician, a part-time physician, or consulting physicians on call. Those rendering the actual medical services generally report to the regional executive medical director. The medical director usually reports to the personnel director or to an officer of the Board of Directors. Since the Board sets the original policy for the department, the medical director reporting directly to the Board is usually in the most favorable position to implement his program. He does not have to "sell" it to those who first gave it birth.

Private physician's role

The private physician who does industrial work should be familiar with the industry's medical policy and should be willing and able to act as medical advisor if requested to do so. If a medical director is available, he should maintain close liaison with him and have periodic visits with him to discuss mutual problems. In a clinic type of practice doing industrial work for several industries, we have found it helpful to appoint one doctor as liaison man for each company to interpret policy and see that quality of service is good. Such things as promptness of written reports, completeness of records, and advance telephonic reports of examinations help to make the industry's organization run smoothly. It is also helpful to delegate one office girl to process all patients to be sure that all necessary information is completed before the patient leaves the medical office. The liaison physician, with the help of the office girl in charge, should be sure that annual reports are made to the industry and that individual reports are made to patients

who have other than pre-employment examinations. In these instances, a copy of the report and recommendations should also be sent to the examinee's own private physician, if he has one.

Summary

The organization of an industrial health department is dependent upon its function. This, in turn, is effected by the health policy which is determined by the philosophy of top management. Although there seems to be a general movement in the direction of increased services, organizational plans vary tremendously. Recognition of these differences from company to company and the reasons for them will help those who care for industrial patients to give better service to the company involved. We can also help to correct some of the misunderstanding among our colleagues when questions are raised about the objectives or methods or marked differences between industrial health departments. •

Postgraduate Program in Israel

The U.C.L.A. School of Medicine, in cooperation with the Hebrew University-Hadassah Medical School in Jerusalem and the Beilinson and Tel Hashomer Hospitals in Tel-Aviv, is offering a Clinical Postgraduate Program in Israel next April 20-May 7.

This program will offer an exceptional opportunity for physicians from the United States not only to attend an excellent medical program, but also to visit in the homes of Israeli physicians and participate in numerous social events which are being planned.

Intraperitoneal cont. from page 27

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Glucosamine cont. from page 30

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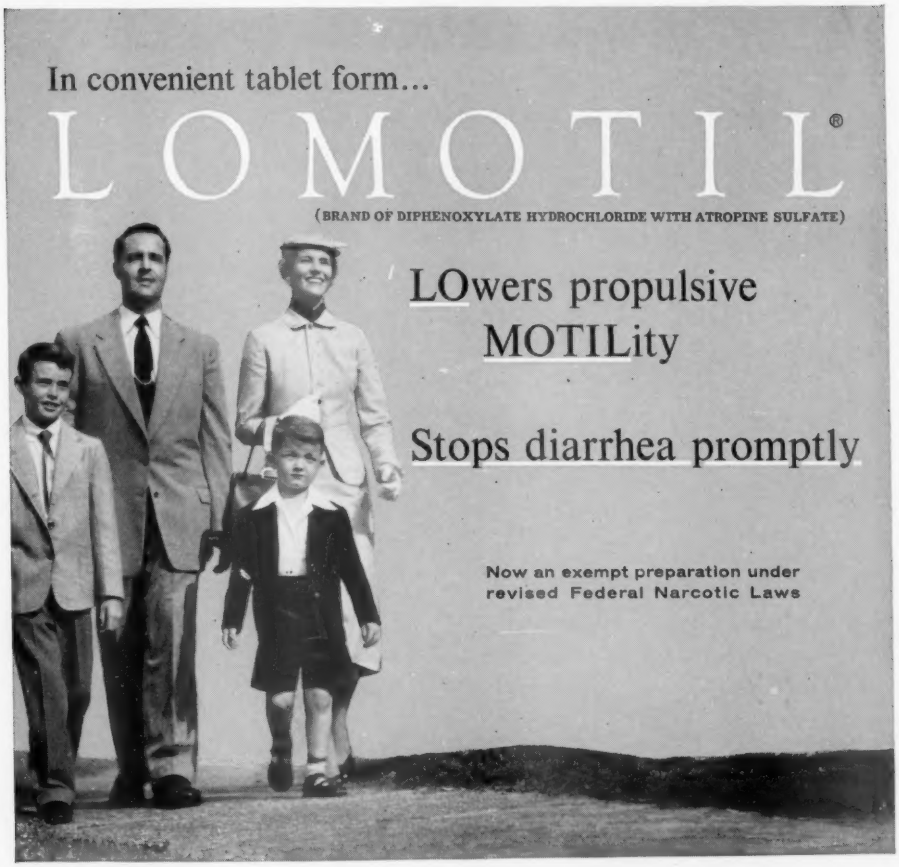

Extensive clinical experience in the United States and Europe demonstrates that Lomotil provides prompt and positive symptomatic control of diarrhea.

Lomotil possesses a highly efficient antiperistaltic action. It controls diarrhea with few or none of the undesirable side effects of many other commonly used antiperistaltic agents.

In the control of diarrhea, Lomotil offers safety, efficacy and greater convenience.

DOSAGE: The recommended initial dosage for adults is two tablets (2.5 mg. each) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is under control. Maintenance dosage may be as low as two tablets daily. Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is supplied as unscored, uncoated white tablets of 2.5 mg., each containing 0.025 mg. ($\frac{1}{2400}$ grain) of atropine sulfate to discourage deliberate overdosage.

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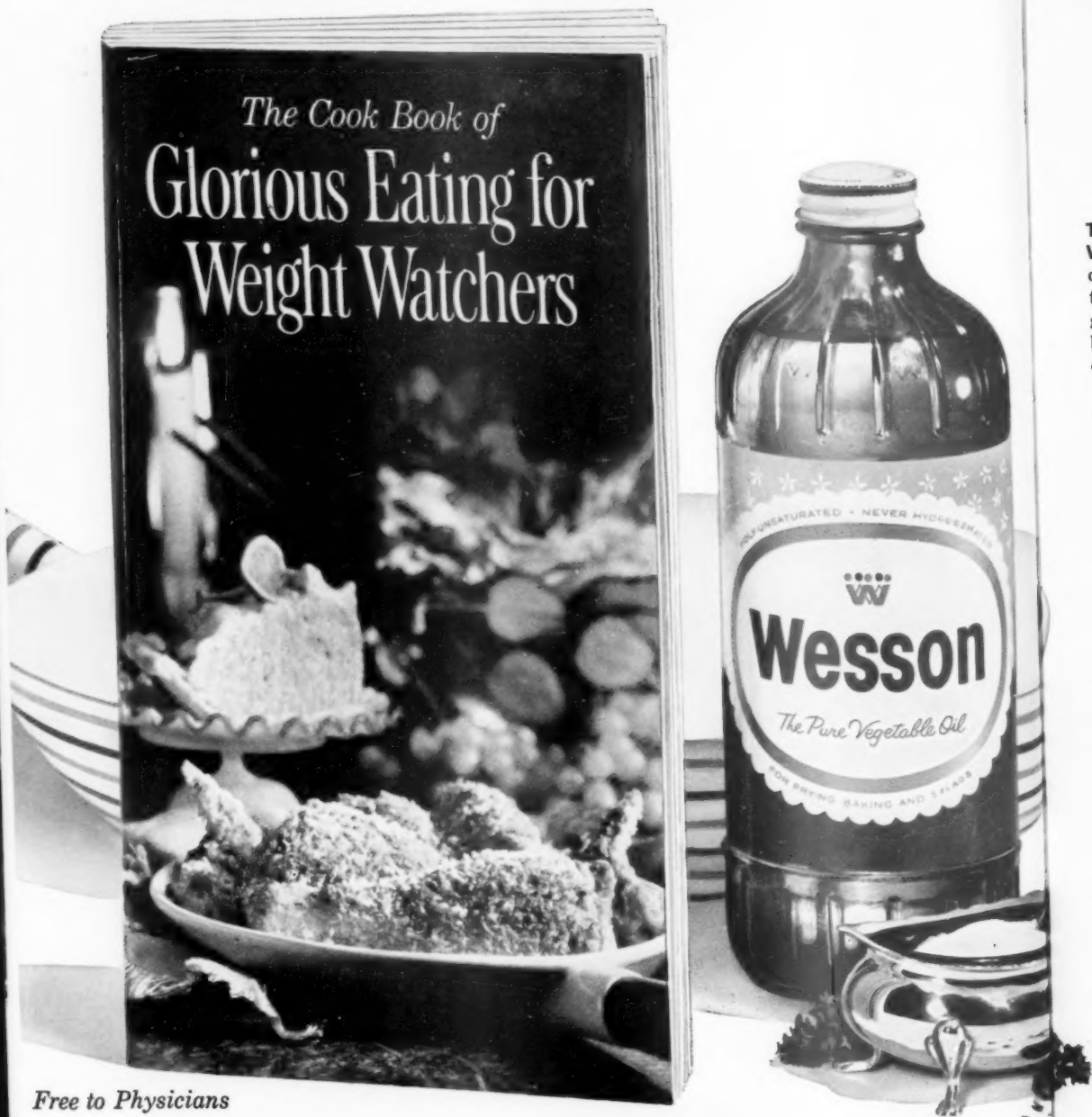

Free to Physicians

Menus fulfill the recommended dietary allowances of the Food & Nutrition Board of the National Research Council.

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Recipes and Menus that Provide Satiety and Appetite Appeal

The Cook Book of Glorious Eating for Weight Watchers fills the long-felt need for a weight control plan that is workable for everybody in the family. Realistic regimens are built around good, natural, readily-available foods enhanced by delicious methods of preparation. In place of "fad diets" or tasteless formulas, it provides for truly appetizing meals. It teaches and encourages the development of the healthful eating habits that can prevent overweight, America's #1 Health Problem. This full-color Cook Book contains 100 pages—248 delicious recipes each with calorie counts. Complete menus are here at 3 calorie levels—1200, 1800, 2600. Calorie levels are related to "best" weights by sex, age, size and extent of activity.

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The Wesson way offers calorie controlled menus that emphasize appetite appeal, variety and satisfaction. They fulfill the recommended dietary allowances of the Food & Nutrition Board of the National Research Council.

All menus provide the proper amount of protein, carbohydrates, fat and the other essential nutrients. The principles of good nutrition are included to help the homemaker plan her own properly balanced, calorie controlled menus. With simple subtractions or additions to the same basic menu, each family member can be served delicious satisfying menus according to his individual needs.

Advance copies for physicians. "The Cook Book of Glorious Eating for Weight Watchers" has not yet been released to the general public. If you would like an advance copy for yourself, together with forms to enable patients to obtain their own *free* copies, please fill in coupon below.

Poly-unsaturated Wesson is unsurpassed by any readily available brand where a vegetable (salad) oil is medically recommended for a cholesterol depressant regimen. As an aid to physicians, Wesson has made available "Your Cholesterol Depressant Diet Book". This book is for professional distribution only—not offered *to laymen.*

Please do not confuse that offer with this one. "The Cook Book of Glorious Eating for Weight Watchers" *will be offered to the general public. It should be explained that this is not a reducing manual. Rather, it marks the first time that a major food manufacturer has taken so important a step in the interest of* prevention of obesity. *Therefore, it is expected that this new book will be highly useful to physicians in their practice.*

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attains activity levels promptly

DECLOMYCIN Demethylchlortetracycline attains—usually within two hours—blood levels more than adequate to suppress susceptible pathogens—on daily dosages substantially lower than those required to elicit antibiotic activity of comparable intensity with other tetracyclines. The average, effective, adult daily dose of other tetracyclines is 1 Gm. With DECLOMYCIN, it is only 600 mg.

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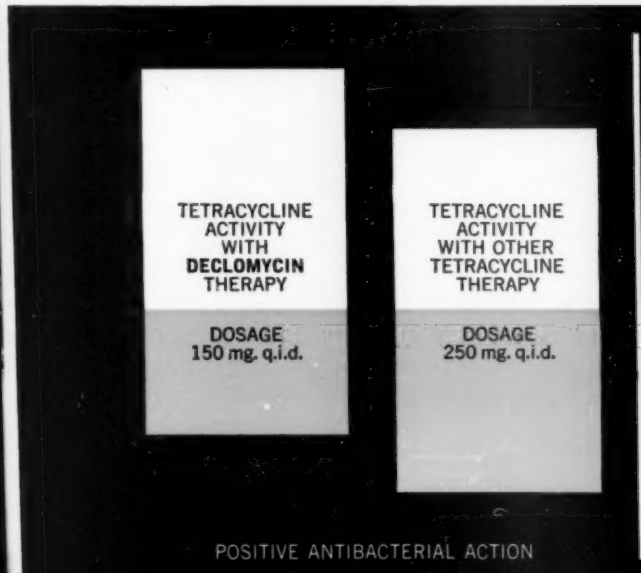
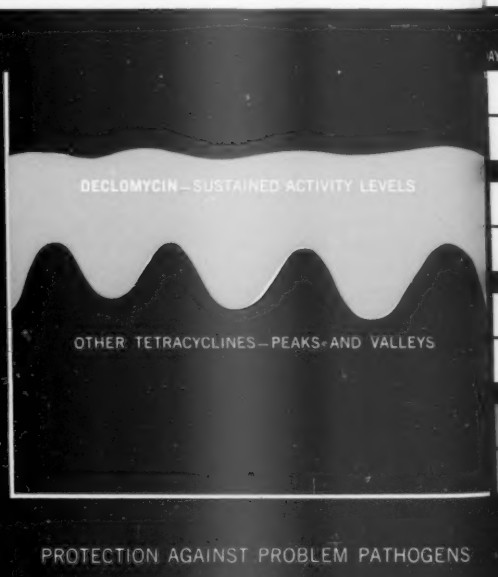
DECLOMYCIN Demethylchlortetracycline sustain through the entire therapeutic course, the high activity le ity levels needed to control the primary infection given. A to check secondary infection at the original—or hus be another—site. This combined action is usually sdosage tained without the pronounced hour-to-hour, dose-s the dose, peak-and-valley fluctuations which charadosage terize other tetracyclines.



POSITIVE ANTIBACTERIAL ACTION



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retains activity levels 24-48 hrs.

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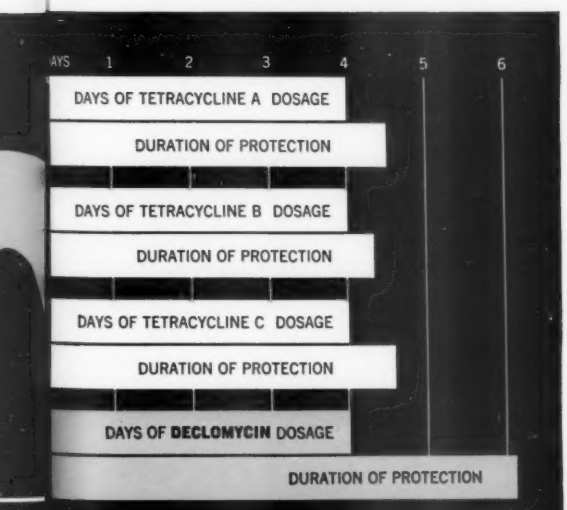

CAPSULES, 150 mg., bottles of 16 and 100. **Dosage:** Average infections—1 capsule four times daily. Severe infections—Initial dose of 2 capsules, then 1 capsule every six hours.

PEDIATRIC DROPS, 60 mg./cc. in 10 cc. bottle with calibrated, plastic dropper. **Dosage:** 1 to 2 drops (3 to 6 mg.) per pound body weight per day—divided into 4 doses.

SYRUP, 75 mg./5 cc. teaspoonful (cherry-flavored), bottles of 2 and 16 fl. oz. **Dosage:** 3 to 6 mg. per pound body weight per day—divided into 4 doses.

PRECAUTIONS—As with other antibiotics, DECLOMYCIN may occasionally give rise to glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis or dermatitis. A photodynamic reaction to sunlight has been observed in a few patients on DECLOMYCIN. Although reversible by discontinuing therapy, patients should avoid exposure to intense sunlight. If adverse reaction or idiosyncrasy occurs, discontinue medication.

Overgrowth of nonsusceptible organisms is a possibility with DECLOMYCIN, as with other antibiotics. The patient should be kept under constant observation.

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THE WASHINGTON SCENE

A monthly news summary from the nation's capital by the Washington Office of the A.M.A.

President Kennedy asked Congress to increase Social Security taxes to finance limited medical care for elderly persons on the Social Security rolls, a plan opposed by the medical profession.

The proposal was part of a sweeping health program outlined by Kennedy in a special message to Congress during his first month in the White House.

The Kennedy program also included federal aid for construction and operation of medical schools, scholarships for medical and dental students, grants for community nursing and hospital services, stepped-up medical research and expanded federal activity in the field of child and youth health.

Under Kennedy's proposal, Social Security beneficiaries 65 years and older could get up to 90 days of hospitalization for each single illness. However, the patient would have to pay $10 daily for the first nine days of hospitalization with a minimum payment of $20.

After release from a hospital, the elderly person could get up to 180 days in a nursing home. The Social Security program also would provide for payment by the government of all out-patient diagnostic costs in excess of $20 and community visiting nurse services.

The program would be financed by increased Social Security taxes by one-fourth of one per cent on both employers and workers and by three-eighths of one per cent on self-employed persons covered by Social Security. The Social Security tax base also would be increased from the present $4,800 a year to $5,000.

Enactment of this proposal, coupled with another Kennedy recommendation and increases in the Social Security tax already scheduled in the law, would mean that workers and employers would be paying $250 each in Social Security taxes in 1969.

Nationwide television audiences were told by an American Medical Association spokesman why the medical profession supports the Kerr-Mills program of medical care for the aged and opposes tieing it in with Social Security.

In television debates with Sen. Hubert Humphrey (D., Minn.) on NBC-TV and Walter Reuther,

organized labor spokesman, on CBS-TV, Dr. Edward R. Annis of Miami, Fla., described the Kerr-Mills program as "sound and effective." He said it "must be given the chance it deserves."

"Congress passed it because it believed that the important thing was to help the people who need help; to help them quickly; and to help them through the machinery of local government," Dr. Annis said.

The A.M.A. Board of Trustees charged the CBS network with "misrepresentations, bias, and distortions" on another program: "The Business of Health—Medicine, Money and Politics."

The network edited out of the taped program the A.M.A.'s true position on health care for the aged:

"The A.M.A. believes that any medical care plan is both unsound and unfair which would compel working people to shoulder increased Social Security taxes to finance health costs of all those over 65 (under Social Security), rich and poor alike, regardless of whether they want or need such help and which, at the same time, ignores millions of indigent elderly who do need help."

Kennedy's health program faced strong opposition in Congress. The consensus of Capitol Hill observers was that it stood a 50-50 chance of getting Congressional approval but not before it had been cut down. There were some who doubted that the Administration's program for medical care of the aged would be acted upon, at least by both houses of Congress before next year.

Even some Democratic Congressmen with the liberal label were taken back by the scope of Kennedy's health program.

Arthur H. Motley, President of the Chamber of Commerce of the United States, warned that Social Security taxes are being increased to a point "where people might rebel against the whole Social Security system."

He contended that this nation's present personal medical care system is the best of any large nation.

"It's worth crusading for and that is what the Chamber is doing," Motley said.

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For neuralgias, dysmenorrhea, upper respiratory distress, postsurgical conditions... new compound kills pain, stops tension, reduces fever—gives more complete relief than other analgesics.

Soma Compound is an entirely new, totally different analgesic combination that contains three drugs. First, Soma: a new type of analgesic that has proved to be highly effective in relieving both pain and tension.* Second, phenacetin: a "standard" analgesic and antipyretic. Third, caffeine: a safe, mild stimulant for elevation of mood. As a result, the patient gets more complete relief than he does with other analgesics.

Soma Compound is nonnarcotic and nonaddicting. It reduces pain perception without impairing the natural defense reflexes.*

NEW NONNARCOTIC ANALGESIC

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Composition: Soma (carisoprodol), 200 mg.; phenacetin, 160 mg.; caffeine, 32 mg.
Dosage: 1 or 2 tablets q.i.d.
Supplied: Bottles of 50 apricot-colored, scored tablets.

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**References available on request.*

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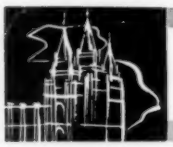


UTAH

Receives grant

Gerald T. Perkoff, M.D., research assistant professor of medicine, has been named the individual to carry out the work on a long-term professorship grant of $54,000 from the National Foundation for Neuromuscular Diseases made to the University of Utah. Dr. Perkoff, who has carried on research since 1955 in the field of metabolic disorders with emphasis on muscular dystrophy and allied neuromuscular diseases, will have his teaching and research work supported for five years under the terms of the NFND grant.

Elected Chamber of Commerce President in Ogden

Drew M. Petersen, M.D., has been elected President of the Ogden Chamber of Commerce. He formally took office as the climax to the Chamber's Annual Membership Meeting on January 12, 1961, in the Hotel Ben Lomond in Ogden. Dr. Petersen is the USMA's Delegate to the American Medical Association.

Receives honor

H. B. McQuarrie, M.D., Ephriam, Utah, received the candle at the 19th Annual Candlelight Services at Snow College Auditorium. Each year a member of the community is honored with presentation of a candle for outstanding services in community affairs. The event is sponsored by Ephraim Junior High School.

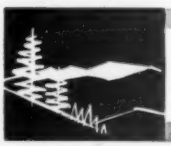
Elected to Board of Directors

Homer E. Smith, M.D., has been elected to the Board of Directors of the National Society for the Prevention of Blindness for a three-year term. Dr. Smith is a member of the Salt Lake County Medical Society and is Chairman of the Fee Schedule Committee of the Utah State Medical Association.

Obituary

G. B. MADSEN

George Bertram Madsen, M.D., prominent physician and civic worker from Mt. Pleasant, Utah, died January 11, 1961, at the Mt. Pleasant Hospital where he had been conducting surgery. Dr. Madsen was a member of the Central Utah Medical Society, of which he was President in 1928-1929. He was a member of the USMA and the American Medical Association. He attended the University of Utah and graduated from the University of Louisville Medical School, Louisville, Kentucky.



COLORADO

Western Slope Spring Clinic

Announcing the Western Slope Spring Clinic—Friday, April 21, and Saturday, April 22, 1961.

The new features of this year's program will include workshop groups conducted by the guest speakers on a variety of interesting subjects, and a "case of the day" where an unknown case will be presented to the guest speakers as well as to the registrants, having the speaker discuss the cases.

The following guest speakers are scheduled to appear: John Caffey, M.D., Pediatric Radiologist, Denver Children's Hospital, Denver, Colorado; Wm. Clatworthy, M.D., Pediatric Surgeon, Children's Hospital, Columbus, Ohio; Edward Mortimer, M.D., Pediatrician, Western Reserve University, Cleveland, Ohio; Wm. Williamson, M.D., Neurosurgeon, University of Kansas, Kansas City, Kansas; James Miles, M.D., Orthopedist, University of Colorado, Denver, Colorado.

Cochems Competition announced

The University of Colorado School of Medicine announces the Cochems Competition, funds for which were provided in the will of the late Mrs. Jane Nugent Cochems. A prize of $2,500 will be awarded to the author of the best paper on the subject of "The Diagnosis, Etiology and Treatment of Thrombophlebitis." The competition is open to all physicians, and entries must be received, in triplicate, on or before October 1, 1961.

The Colorado National Bank of Denver, Trustee under the will of Jane Nugent Cochems, has requested the Dean of the University of Colorado School of Medicine to conduct the competition. The judges, appointed by him, are Dr. Michael E. DeBakey, Professor and Head of the Department of Surgery, Baylor University College of Medicine, and Dr. Sol Sherry, Professor of Medicine, Washington University School of Medicine.

Papers submitted in the competition may not be published until after the winner of the competition has been announced. At that time, the winning paper and all others may be published at the discretion of individual authors. It should be noted, however, that those involved in conducting the competition will not assume any responsibility

for submitting manuscripts for publication nor for any costs incident thereto. The winning paper, if published, must carry the designation, "Awarded the Jane Nugent Cochems Prize."

Questions regarding the competition and all manuscripts should be directed to Dr. Robert J. Glaser, Vice President for Medical Affairs and Dean of the University of Colorado School of Medicine, University of Colorado Medical Center, 4200 East Ninth Avenue, Denver 20, Colorado.

Obituaries

Life member dies in California

Frederick Henry Weber, M.D., died on December 27, 1960, in Loma Linde, California, where he and his wife, Dr. Mary Jackson Weber, had been living since their retirement from practice. Dr. Weber was born in Dayton, Ohio, on January 31, 1875, and received his preliminary education at Battle Creek College in Michigan. He received a Ph.B. degree from Colorado State University in 1902, an A.B. degree from Iowa State University in 1909 and his M.D. degree from the University of Colorado in 1912. He married Dr. Mary Jackson, also a C.U. graduate in medicine, in 1911.

Dr. Fred H. Weber was licensed in Colorado, Massachusetts, Ohio and Arizona and his specialty was psychiatry and neurology. He practiced in Boulder at Boulder Sanitarium from 1913 to 1918, at Idaho Springs from 1918 to 1922, and was on the staff of the New England Sanitarium at Melrose, Mass., from 1922 to 1925. Later he was a psychiatrist at the Harding Sanitarium at Worthington, Ohio, from 1930 to 1944. Later his wife and he rejoined the Boulder Sanitarium and were there until the fall of 1947, when they left for Phoenix, Arizona, and practiced there.

Dr. Weber was a member of the Boulder County Medical Society and was elected honorary member of that society in 1946. He was a member of the Ohio Medical Society and also of the Massachusetts Medical Society. In 1954, he became a life emeritus member of the Colorado State Medical Society.

Surviving the doctor are his wife, a daughter and a son. The daughter is the wife of a doctor practicing at Alhambra, California, and the son is a physician in Miami, Florida.

Boulder mourns retired Army colonel

Dr. Albert Bowen, retired U. S. Army Colonel and roentgenologist, died in Boulder on January 7, 1961, at the age of 78, from complications following a fractured hip. He had been ill with Parkinson's disease and had been almost completely incapacitated for the last year.

Albert Bowen, M.D., was born in Rochester, New York, on July 26, 1883, and received his A.B. degree from the University of Rochester in 1906. In 1911, he graduated as a doctor from the University of Pennsylvania and practiced in Rochester prior to entering the Army Medical Corps. He interned at Queens Hospital in Honolulu and did postgraduate work in Vienna in 1913. During World War I, Dr. Bowen served in France and Germany and later was stationed at various camps throughout the United States. Dr. Bowen served a residency at Massachusetts General Hospital in 1925 and at Walter Reed Hospital in 1928 and 1929.

He became radiologist at Fitzsimons Hospital and later at Tripler, Brooke and Lawson General Hospitals. During the time Camp Maxey, Texas, was in operation, Dr. Bowen was commanding officer. At Fort Logan, he was post surgeon until the Fort closed.

In 1946, Dr. Bowen moved to Boulder and became a member of Boulder County Medical Society. He and his wife, Dr. Amy Metcalf, practiced in Boulder and then he became radiologist at both the University Student Health Center and Community Hospital, retiring from that work a year ago.

Dr. Bowen was very active in the Unitarian Church and helped in founding the fellowship there. He served as its President for a time and as a member of the Board of Trustees for many years.

In 1954 he became a life emeritus member of the Colorado State Medical Society.

Dr. Amy Metcalf, his wife, survives him as well as three children, one being a pediatrician in Spokane, Washington.

Dr. Ella Mead leaves us

Dr. Ella A. Mead, pioneer Weld County physician, woman leader extraordinary in all good things civic, medical and in public health, passed away January 12 in Greeley following a long illness. She had passed the age of 86, having been born in Moravia, New York, July 26, 1874.

Ella Avery Mead served as an elected officer of the Colorado State Medical Society longer than any other physician in the Society's history—27 years—nine consecutive three-year terms as a member of the Board of Councilors, and many of those years as its Chairman. Even before that she served a term as Vice President of the Society. As such she was the guiding light of medical ethics in Colorado from 1926 through 1953 and responsible for much of the favorable comment nationally on the high standards of medical ethics in this region. She also served one or more terms in every elective office of the Weld County Medical Society, took part in scores of civic activities, led in the modernization of the Weld County Health Department and was its health officer for several years after advancing age forced her to retire in 1954. Her professional accomplishments are too numerous to mention. On many occasions Dr. Mead received national recognition for her status. In 1947 she was honored with a Certificate

of Service for professional and scientific accomplishments in medical practice. In 1958 she received the Florence Sabin award from the Colorado Public Health Association. In that year also she received the Medical Woman of the Year award and a citation from the National Medical Association meeting in Washington, D. C. She was honored by the Weld County General Hospital in the dedication of the new nurses' home bearing the name "Ella A. Mead Hall."

Dr. Ella Mead was beloved by every physician in the state who had the opportunity of knowing her. Her contribution as a physician and as a woman will be an inspiration for many years.

Proceedings of the House of Delegates*
Third Interim Session
New Mexico Medical Society

November 4-5, 1960

Carlsbad, New Mexico

FIRST SESSION

Speaker C. Pardue Bunch, M.D., called the House to order at 2:00 p.m. at the Riverside Country Club, Carlsbad, New Mexico.

Secretary-Treasurer T. L. Carr, M.D., Albuquerque, reported a quorum present.

The minutes of the last meeting were approved.

George H. Curfman, M.D., member of the Board of Directors, Colorado Blue Shield, brought greetings to the House of Delegates from the Colorado Blue Shield Program and the Colorado State Medical Society and addressed the House of Delegates on "A Physician's Approach to Prepayment Medical Care."

M. D. Thomas, M.D., El Paso, Fraternal Delegate from Texas, brought greetings from the Texas State Medical Association.

Allan L. Haynes, M.D., President, New Mexico Medical Society, reported to the House of Delegates on the stewardship of his office.

The Speaker reported the reference committee appointments and officially referred business to them which had been published in the Handbook

The following resolution, submitted by Omar Legant, M.D., was referred to the Reference Committee on Legislation and Public Affairs:

Resolutions

RESOLVED, That the House of Delegates of the New Mexico Medical Society urge the State of New Mexico Public Welfare Department to earnestly and seriously consider assigning the responsibility for the administration of welfare medical aid to New Mexico Blue Cross-Blue Shield. The House of Delegates goes on record as affirming this action for the best interest not only of the medical profession but the people of New Mexico.

The Speaker reported that the following resolution was submitted by William F. Blank, M.D., as a supplement to the Bernalillo County Medical Association resolution, as a matter of information, and the Speaker referred this to the Reference Committee on Legislation and Public Affairs:

WHEREAS, Present conditions are resulting in preparation and introduction of legislation to deal with periods of disaster-emergency, and

WHEREAS, Such legislation is essential to the operation of government during such periods, and

WHEREAS, Such legislation can have a serious impact upon the constitutional rights of individuals and upon the normal processes of government, including judicial administration; now, therefore, be it

RESOLVED, By the State Bar of New Mexico, that the members of the Bar in New Mexico take it upon themselves to assist in preparation of appropriate legislation to serve these purposes and review legislation proposed for the purpose of making certain that such legislation does not unduly infringe upon constitutional rights and is limited to the requirements necessitated by the disaster emergency, and be it further

RESOLVED, That the President of the State Bar Association consider the appointment of a special committee for the consideration of these matters.

Proposed Amendments to the By-Laws

The following Proposed Amendments to the By-Laws, submitted by the Constitution and By-Laws Committee, were referred to the Reference Committee on Administrative Matters:

1. Page 5, Chapter 1, Section 1. After "which has paid its annual assessment," insert: "on or before March 1st." After sentence ending "prima facie evidence of membership in the Society," insert: "Any member failing to pay his annual assessment on or before March 1st shall be subject to expulsion by action of the Council. Any member expelled by the Council for nonpayment of dues may apply for reinstatement upon payment of all delinquent assessments and the payment of a $25 reinstatement fee. He may then be reinstated at the discretion of the Council."

2. Page 7, Chapter IV, Section 2: After "who have paid their dues," insert: "as hereinbefore stated."

The supplemental report of the Council was referred to the Reference Committee on Administrative Matters:

Supplemental report of the Council

The Council of the New Mexico Medical Society met Thursday, November 3, 1960, at La Caverna Hotel, Carlsbad, N. M., and took the following actions:

*Condensed from the shorthand record of Mrs. Ralph Marshall, reporter. Records referred to but not reproduced herein were distributed to all members of the House of Delegates at the Annual Meeting in the mimeographed Handbook, or were distributed to all members of the House in mimeographed form at the opening session. Copies of such reports are on file in the executive offices of the Society and are available for study by any members of the Society.

1. Approved: That a copy of the Medical Practice Act, as proposed, be presented to the reference committee considering the Legislative Committee report and the report of the Council, which should clarify the intent of the bill.

2. Approved: That paragraph 23 of the Council minutes of August 20, 1960, be altered from "that only duly elected Delegates of County Societies may introduce resolutions in the House of Delegates," to "only duly elected members of the House of Delegates may introduce resolutions in the House of Delegates."

3. Approved: That the application for membership-at-large of G. A. W. D'Andrea, M.D., Santa Rosa, be submitted to the House of Delegates for approval.

4. Approved: That Andres Ferret, M.D., Santa Fe, be granted an Emeritus Membership status for one year, retroactive to the first of January, 1960.

5. Confirmed: The appointment of Richard Angle, M.D., Santa Fe, to serve as a member of the Convention Scientific Program Committee, replacing Burgess Gordon, M.D., who has resigned from this committee and has left the state.

6. Approved: That beginning with the 1961 meeting that an honorarium in an amount deemed advisable by the Council be granted to guest speakers and that the Convention Scientific Program Committee be informed of this.

7. Approved: That an honorarium of $100 be paid guest speakers at the 1961 Annual Meeting.

8. Approved: The request from Eddy County Medical Society for R. F. Brown, M.D., to be declared an Emeritus Member by virtue of his retirement from practice.

9. Approved: That the Chairman of the Constitution and By-Laws Committee review the Constitution and By-Laws and make recommendations either at the House of Delegates' meeting Friday or at the next meeting of the Council with reference to having these printed at this time.

10. Tabled: A request from the Auxiliary to have Auxiliary dues added to physicians' dues and collected by the New Mexico Medical Society.

11. Approved: That members be encouraged to join the Chamber of Commerce as individuals, but that the State Society should not join this organization as a group.

12. Approved: That the members of the Contracting Committee for Medicare confer with Mr. Houk concerning the best approach to try to resolve the misunderstanding which has arisen regarding payment of Medicare obstetrical fees on a trimester basis, dating back to April 1, 1958, for which the government is seeking restitution, and authorize the expense of one or more of the members to go to Iowa or Washington, or both, if necessary.

13. Disapproved: The expenses of William F. Sears, M.D., Chairman, Mental Health Committee, to attend the meeting of the A.M.A. Council on Mental Health, to be held in Chicago, January 20, 21, because of budgetary limitations.

14. Approved: That our State President be asked to appoint a committee to consider our present and possible future financial position and make recommendations to the Council on the following items:

a. The best utilization of our money in the budget.

b. Increased expenses, such as annual stipend for the State President.

c. Consider the need for an increase in the State Society income as included in our annual dues, registration fees, exhibitors' fees, etc.

The following were appointed by Dr. Haynes to serve on the above committee: Drs. T. L. Carr, Chairman, L. M. Overton and William F. Oakes.

15. Expressed appreciation: To Dr. Haynes for the excellent way he has conducted correspondence with Senator Anderson concerning proposed medical aid legislation.

16. Approved: That New Mexico Physicians' Service be directed to make every possible attempt to see that the new proposed fee schedule for Blue Shield in New Mexico be submitted to the House of Delegates in May, 1961.

Report of Committee to Consider Financial Position of New Mexico Medical Society

At the request of the President of the New Mexico Medical Society this committee met to consider problems related to the budget and monies available for the running of the Society. The budget has been carefully studied by our committee.

The close present balance between income and outgo in our budget, with the lack of provision for emergency funds for new needs in the running of our Society, indicates that almost no request for funds can be considered as "no money is available" in the budget.

The scope of organized medicine has extended beyond the individual physician and this entails considerable conference and travel on the part of representatives of the Society, the expense of which should not be required to be borne by the individual physician.

continued on page 64

After a history and a physical ruled out organic disease, the physician diagnosed the case as recurring states of anxiety. To relieve these symptoms for this busy, on-the-go housewife, he prescribes Meprospan-400, the *only* meprobamate in *sustained-release* form.

As directed, the patient takes one Meprospan-400 capsule at breakfast. Her symptoms of tension and nervousness are soon relieved, and she will not have to remember to take another capsule until dinnertime.

Calm and relaxed, the patient is no longer upset by the pressures and irritations met in everyday life, nor is she likely to be incapacitated by autonomic disturbances, drowsiness, ataxia or other untoward reactions.

Alert and attentive, the patient participates in a P.T.A. meeting, following her second capsule of Meprospan-400 taken with the evening meal. Meprospan-400 does not decrease her mental efficiency or interfere with her normal activities or behavior.

Peacefully asleep, the patient enjoys beneficial rest . . . Meprospan-400 has relieved the tensions that previously prevented sleep or kept her tossing and turning throughout the night.

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ONE CAPSULE LASTS 12 HOURS

Meprospan®-400

400 mg. MILTOWN® SUSTAINED-RELEASE CAPSULES

Usual dosage: One capsule at breakfast lasts all day, one capsule with evening meal lasts all night. **Supplied:** Meprospan-400, each blue-topped *sustained-release* capsule contains 400 mg. Miltown. Also **available:** Meprospan-200, each yellow-topped *sustained-release* capsule contains 200 mg. Miltown. **For children:** Capsules can be opened and the coated granules mixed with soft foods or liquids.

Both potencies in bottles of 30.

Samples and literature available on request.

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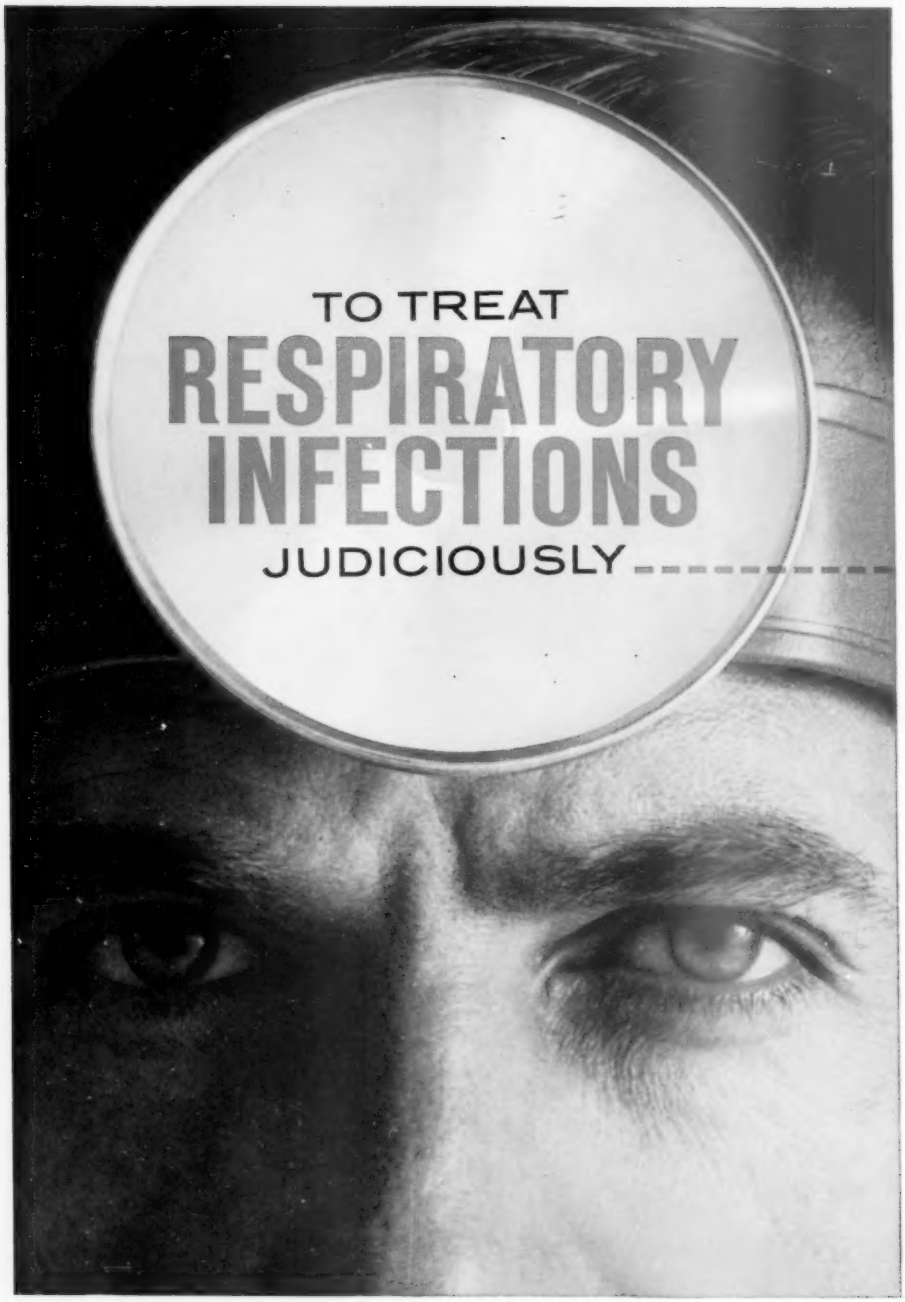

TO TREAT
RESPIRATORY
INFECTIONS
JUDICIOUSLY

Organization cont. from page 60

The relationship between state committees and national committees should be strengthened by allowing more participation by our State Society members on a national and regional basis in functions of the A.M.A. (By this we mean committee members from our state committees should participate in meetings in national and regional committees in their field.)

The national and regional activities also require more constant and prolonged attention of our President, and we should look forward to the time when a stipend may be offered to the President of the New Mexico Medical Society for the time and energies he expends in conducting the functions of his office.

The complexities of the time also increase the amount of work to be done in our State Office organization and our State Office expenses may well require expansion in the near future.

We compliment our Executive Secretary on the way he has held the line with the present budget.

We find no way to make any material reduction in expenses, present and anticipated, for our Society.

To provide funds to carry out necessary functions of our Society will require an additional sum in our budget to be expended under the direction of the Council.

We recommend that approximately $6,000 of increased State Society dues be regularly collected. This would involve additional state dues of $10 per member per year for each of our slightly more than 600 members.

The above report was unanimously approved by the Council at a meeting on November 4th and is recommended for adoption by the House of Delegates.

The Council also approved: That if the House of Delegates agrees to increase the dues of the State Medical Society $10 per year, that the expenses of the Chairman of the Mental Health Committee be paid to attend the meeting of the A.M.A. Council on Mental Health on January 20, 21, in Chicago, Ill.

The following resolution from Chaves County Medical Society was referred to the Reference Committee on Administrative Matters:

Resolution

WHEREAS, In negotiating its fee schedule in connection with the Government Medicare Program, the New Mexico Medical Society desired to eliminate the procedure for payment for prenatal care on a trimester basis and the Negotiating Committee of the State Society was sent to Washington in March, 1958, to negotiate a new contract which would not provide for the payment for prenatal care on a trimester basis; and

WHEREAS, The Negotiating Committee of the Association, consisting of John J. Corcoran, M.D., Jim Sedgwick, M.D., and Ralph Marshall, discussed the deletion of the payment on a trimester basis with the Medicare officials of the government and it was mutually agreed that the new contract would delete the payment on a trimester basis; and

WHEREAS, The Medicare Adjudication Committee advised the members of the New Mexico Medical Association that effective April 1, 1958, that "a new method is used for determining allowable maternity fees. The trimester system is out"; and, therefore, the New Mexico Medical Society published a Medicare Manual and Schedule of Allowances and generally circulated this among the members of the Society and furnished copies of the fee schedule to the Medicare officials in Washington who had negotiated this contract with the Society; and

WHEREAS, Pursuant to the advice received from the Medicare Adjudication Committee and to the Medicare Manual and Schedule of Allowances, the members of the New Mexico Medical Society based their charges upon the schedule and not on the trimester basis; and

WHEREAS, It has recently been discovered that the trimester provision was not deleted from the contract between the New Mexico Medical Society and the government, due to some oversight in preparing the contract and now the government proposes to audit all maternity claims and statements submitted since April 1, 1958, to determine the amount, if any, owed by the Society by reason of services rendered by any of its members which were not charged on a trimester basis; and

WHEREAS, The audit will involve a considerable amount of expense to the Society and to the various members thereof and might result in substantial claims being made against the Society; it is therefore

RESOLVED,

1. That the House of Delegates of the Society instruct the Council and the Medicare Adjudication Committee to immediately contact the officials in charge of the Medicare program and to call their attention to the fact that the contract as executed does not incorporate the agreement between the parties and to demand that the contract be amended, effective April 1, 1958, to express the true intention of the parties.

2. That the Council and the Medicare Adjudication Committee advise the officials in charge of the Medicare program that the New Mexico Medical Society does not feel that it is in any way responsible for the error, since the contract does not express the true intention of the parties, and further, that it does not feel that the Society or its members should be called upon to reimburse the government for any sums which it may claim by reason of charges made which would not have been allowed if the trimester system had been in effect.

3. That the General Counsel of the New Mexico Medical Society be instructed to take such steps as may be necessary to protect the interests of the Society and of any member of the Society against whom a claim may be asserted for failure of the member to make charges on a trimester basis.

4. That in the event that the government refuses to amend the contract as of April 1, 1958, to express the true agreement between the parties as reached as a result of negotiation between the governmnt and the Medicare Adjudication Committee in March, 1958, then the Medicare contract with the government should be cancelled.

It is hereby certified that the above and foregoing is a true and correct copy of the resolution adopted by the Chaves County Medical Society at a regular meeting here in Roswell, Chaves County, New Mexico, on November 2, 1960.

The following proposed resolution from the Council was referred by the Speaker to the Reference Committee on Administrative Matters:

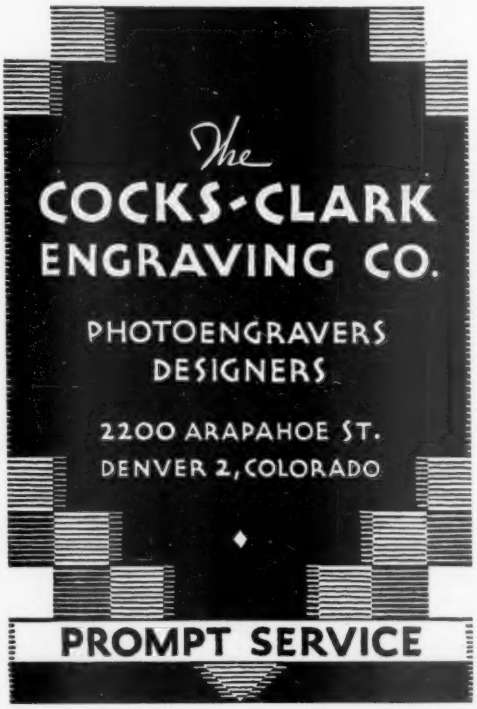
Resolution

WHEREAS, The House of Delegates of this Society in previous sessions has in the course of discussions on other matters, such as prepaid insurance and welfare programs, proclaimed the policy of this Society that physicians will provide care to those in need regardless of ability to pay, and

WHEREAS, These statements have been contained in the minutes of discussions of other issues and have not previously been stated alone and on their own merits, it is the feeling of the Council that this should now be stated directely, as follows:

RESOLVED, It is the policy of the New Mexico Medical Society that its members will stand ready to render medical service to all who are in need of such services regardless of ability or inability to pay.

The following changes in the Medical Practice Act, submitted by the Legislative Committee, were referred to the Reference Committee on Legislation and Public Affairs:



Proposed changes in Medical Practice Act

Section 1.

(1) A person's license to practice medicine and surgery in this state shall be suspended automatically by the Secretary of the New Mexico Board of Medical Examiners upon the following grounds:

a. The entry of a decree by any court of competent jurisdiction within or without the state establishing the insanity or mental illness of any person holding a license to practice medicine and surgery in this state; or

b. The admission of a person licensed to practice medicine and surgery in this state on a voluntary basis to any state hospital which treats or cares for the mentally ill.

(2) a. The Clerk of the Court entering the order of commitment of some court of competent jurisdiction establishing the insanity or mental illness of any person holding a license to practice medicine or surgery in this state shall immediately cause to be mailed to the Secretary of the New Mexico Board of Medical Examiners a certified copy of the court's order adjudging the person to be insane or mentally ill. No fees shall be charged the Clerk of the Court for performing the duties prescribed by this subsection.

b. The Superintendent of the State Hospital to which a person licensed to practice medicine and surgery in this state has voluntarily applied for admission shall immediately cause to be mailed to the Secretary of the New Mexico Board of Medical Examiners a certified copy of the record of the voluntary admission of such person.

(3) A suspension under this section may in the discretion of the Board of Medical Examiners be terminated, but the suspension shall continue and the Board shall not restore to the former practitioner the privilege to practice medicine and surgery in this state until:

a. The Board receives competent evidence that the former practitioner is not mentally ill; and

b. The Board is satisfied in the exercise of its discretion, with due regard for the public interest, that the practitioner's former privilege to practice medicine and surgery may be safely restored;

c. If the Board, in the exercise of its discretion, determines that the practitioner's former privilege to practice medicine and surgery may be safely restored, it may restore such privilege upon whatever terms and conditions it may deem advisable. If the practitioner fails, refuses or neglects to abide by said terms and conditions, his license to practice medicine and surgery may, in the discretion of the Board, be again suspended indefinitely.

The Speaker then declared the Interim Session recessed until 2:00 p.m., November 5, 1960.

SECOND SESSION
November 5, 1960

Vice Speaker of the House Omar Legant, M.D., Albuquerque, called the House of Delegates to order at 2:00 p.m. The Secretary-Treasurer, Thomas L. Carr, M.D., Albuquerque, reported that a quorum was present.

The Vice Speaker introduced Mrs. Stanley J. Leland, President-elect of the Woman's Auxiliary to the New Mexico Medical Society, who made the following report of activities of the Auxiliary, on behalf of Mrs. Avon Flaniken, President, who was unable to be present:

Report of Woman's Auxiliary

"The following are some of the activities in which the Auxiliary is serving. We realize that our husbands are too preoccupied with medicine to have time for all the activities pertaining to it.

"Physicians' wives are united in an organization whose sole purpose is to carry out the projects referred and approved by the medical profession . . . national, state and local.

"The Auxiliary has been waging an active battle against Forand-type legislation, and as an organized group, our voice carried louder.

"We have had representatives to Conferences on Aging in Western Region presenting problems and views from all sections of our country.

"We contribute to AMEF direct donations, fund-raising activities and other contributions.

"We supply materials and work with local

clubs, schools, organizations on safety, legislation, medical recruitment, and general health education.

"On a local level, we attempt any task given us by the medical society, and when the state medical meetings are held in our area, we attempt to organize as much of the program as is needed by procuring entertainment and meeting places.

"We try to educate our group and any other in matters of civil defense and safety programs.

"Sponsoring two state scholarships for nurses or other para-medical careers is another function. Several county organizations sponsor educational scholarships.

"Many of the county societies sponsor candy-stripers (young girls who work as nurses' aides in hospitals) and do other work which is needed within the hospital.

"We have a new project, suggested by the A.M.A., Rural Health, which is designed to assist the rural people help themselves in matters of health.

"If there is a way in which we can serve in addition to these, please do not hesitate to call upon us."

Nominating Committee report

Stuart W. Adler, M.D., Acting Chairman, Nominating Committee, gave the following report:

The Nominating Committee submits the following names as nominees from which the Board of Directors of the Blue Shield will select seven at its meeting in March:

E. K. Neidich, M.D., Las Cruces
Leland S. Evans, M.D., Las Cruces
Frank A. Parker, M.D., Gallup
Jose Rivas, M.D., Belen
M. F. Green, M.D., Clovis
H. O. Lehmann, M.D., Portales
Lorry C. Delambre, M.D., Albuquerque
Glenn Margard, M.D., Albuquerque
Karl Mast, M.D., Santa Fe
W. J. Natoli, M.D., Los Alamos
Earl L. Malone, M.D., Roswell
R. P. Waggoner, M.D., Roswell
David B. Post, M.D., Albuquerque
R. P. Beaudette, M.D., Raton

The Vice Speaker reported that in considering the reports of the reference committees, that each report has been signed by two members of the reference committee. Therefore, it would not be necessary to second motions made by the Chairman.

Report of the Reference Committee on Administrative Matters

H. W. Hodde, M.D., Chairman, Reference Committee on Administrative Matters, gave the following report:

Your Reference Committee on Administrative Matters met November 4, 1960, and considered the reports referred to it. It submits the following comments and recommendations:

Report of the A.M.A. Delegate: It is the opinion of the committee that our State Society was very ably represented at the meeting of the American Medical Association, it is the desire of the members of the committee to commend Earl Malone, M.D., for his excellent report.

The committee urges that all members of the Society do take an active part in Conferences on Aging.

The committee suggests that the adoption of the statement of policies referring to National Foundation, approved by the A.M.A., be referred to committee for study. The remainder of the report is informative and needs no action.

We move adoption of this report. The motion was carried unanimously.

Constitution and By-Laws Committee's reports were reviewed, and we recommend adoption of the deletion, as stated in published reports to Article XI.

We move adoption as changed. Motion carried.

Dr. Hodde stated that in the proposed amendments to the By-Laws, the reference committee would move adoption of the following:

Chapter 1. Section 1. That the following be substituted at the beginning of the paragraph:

"A physician who has paid his annual assessment on or before March 1st of the current year, and whose name is on a properly certified roster of members of a component Society, which requires each applicant to be a citizen of the United States of America, or to have filed a declaration of intention to become such a citizen in the office of the Clerk of a court of competent jurisdiction, be of good moral character, a graduate of a medical school, and licensed by the New Mexico Board of Medical Examiners, shall be prima facie evidence of membership in this Society. Membership shall consist of the following classes: etc."

That the following new subsection be added:

"Chapter 1, Section 1 g. The annual assessment is due and payable January 1st and is delinquent as of March 1st of the current year. Any member failing to pay his annual assessment on or before March 1st shall be subject to expulsion by action of the Council. Any member expelled by the Council for nonpayment of dues may apply for reinstatement

upon payment of all delinquent assessments and the payment of a $25 reinstatement fee. He may then be reinstated at the discretion of the Council."

(2) The committee further moves that the proposed amendment of the Constitution and By-Laws Committee, Chapter IV, Section 2, after "who have paid their dues," insert: "as hereinbefore stated," be approved. The motion was unanimously carried.

Dr. Hodde reported that the committee would like to recommend that the Committee on Constitution and By-Laws make a very careful editorial survey of the Constitution and By-Laws in their entirety, with the view of publishing them upon completion.

The Scientific Program Committee's report was reviewed and is for information only. The additional assessment of $5 per member is cared for elsewhere. We move adoption of this report.

L. M. Overton, M.D., moved that this be amended to read that the "additional assessment of $5 is disapproved." H. W. Hodde, M.D., seconded the motion which carried.

Convention Site Committee's report is for information only. We move its adoption. The motion carried.

5. The report and supplemental report of the Council to the House of Delegates has been reviewed, and the committee recommends approval of these reports, with the following exceptions:

a. August 20, 1960: The committee wishes to delete Item 3.

b. August 20, 1960, Item 4: The committee recommends that the paragraph be clarified to read as follows: "That the Enabling Act of 1889 providing for the establishment of a medical school be reaffirmed and that the Legislature grant approval for the establishment of such a school."

c. August 20, 1960, Item 23: This item is accepted as corrected in the supplemental report of the Council, dated November 4, 1960.

d. Supplemental Report of the Council, November 4, 1960, Item 2, which says, "That paragraph 22" should be changed to read, "That paragraph 23."

e. Supplemental Report of the Council, November 4, 1960, Item 9: The reference committee suggests that the By-Laws be reviewed for ambiguity before final decision to print.

We move adoption of the reports of the Council to the House of Delegates, with the above changes. The motion carried.

The report of the Committee Appointed to Consider Financial Position of New Mexico Medical Society has been reviewed. It is the opinion of this committee that the State Society's dues need increasing, but the committee feels $10 will only cover anticipated routine expenses. We suggest an honest increase of $20, hoping it will be sufficient for a few years.

We move adoption of this report, as altered. Joseph Sharpe, M.D., asked that the objections of the San Juan County Medical Society to this increase in dues be registered. The motion carried.

Dr. Hodde's report continued: We move adoption of the resolution from the Council on the care of the indigent.

After discussion, the following amended resolution was approved: "RESOLVED, It is the policy of the New Mexico Medical Society that its members will continue to render medical service to all who are in need of such services, regardless of inability to pay."

Dr. Malone pointed up that the adoption of the above resolution placed upon each individual physician the responsibility of implementing the resolution.

Grievance Committee: The committee recommends that this report be filed for information. The Vice Speaker stated that this report would be filed.

Report of the Board of Trustees of New Mexico Physicians' Service is accepted for information only. We move that this be filed for information only. The Vice Speaker announced that this report would be filed.

Supplemental reports referred to the Reference Committee on Administrative Matters:

The committee recommends disapproval of the Chaves County Medical Society's resolution, because of information subsequently obtained at committee hearing. Dr. Hodde moved that this be disapproved. The motion carried.

The recommendation from our President, A. L. Haynes, M.D., for a list of committees required to report annually is not submitted, in that designation of these committees might create unsatisfactory results. We suggest that requests for reports prior to each meeting be sent and those committees in which there has been activity or who have pertinent information only report. However, it is the opinion of this committee that all committees should report at least annually.

Dr. Hodde then moved that the report of the Reference Committee on Administrative Matters, as amended, be accepted. The motion carried.

Dr. Hodde expressed his appreciation to the members of his committee for their excellent work.

The Vice Speaker turned the meeting over to the Speaker of the House, Dr. Bunch.

R. R. Boice, M.D., gave the following reference committee reports:

Reference Committee on Legislation and Public Affairs

Advisory Committee to Board of Regents: The committee recommends adoption of the report with the following additions: Since the impetus towards the establishment of the medical school came from the Tri-County Medical Society and large amounts of its funds were expended in the effort, it is suggested that a member of this County Society be appointed to the committee.

This portion of the report was adopted.

Advisory Committee to Department of Public Welfare: Supplementary reports: The committee moves that the report be adopted with the following changes: That beginning with

line 7 that lines 7 and 8 be changed to read: "The plan would obligate these persons to pay in any given three-months period of care the first $10 in each of the three categories of any medical, drug, or hospital bill, with the government program paying all costs above this initial $10 under the D.P.W. fee schedule in effect at the time."

Earl Malone, M.D., reported that this report submitted to the House of Delegates by the Advisory Committee to the Department of Public Welfare was the result of two members of the committee's work, and the report does not reflect the views of all the members of the committee; it was impossible for some of the members of the committee to meet on the date set for the hearing.

After considerable discussion, William Oakes, M.D., moved that this matter be postponed until the House of Delegates has discussed the Blue Cross-Blue Shield resolution. Eugene Szerlip, M.D., seconded the motion, which carried. The Chair ruled that discussion of the Blue Cross-Blue Shield resolution be held at this time.

Dr. Boice reported that the reference committee moves that the resolution considering assigning the responsibility for the administration of welfare medical aid to New Mexico Blue Cross-Blue Shield not be approved, because of insufficient information. After discussion, Dr. Boice withdrew his motion.

S. W. Adler, M.D., moved that the resolution be changed to read:

"RESOLVED, That the House of Delegates of the New Mexico Medical Society urge the State of New Mexico Public Welfare Department to earnestly and seriously consider assigning the responsibility for administration of additional care for the aged under existing federal legislation known as the Mills-Kerr Bill, to New Mexico Blue Cross-Blue Shield, etc." William Oakes, M.D., seconded the motion, which carried, by a vote of 19 in favor, 15 opposed.

The Speaker reported that discussion would resume on the recommendation of the reference committee on the report of the Advisory Committee to the Department of Public Welfare.

R. C. Derbyshire, M.D., moved that the House of Delegates take no action on this at present, and that the matter be referred back to the Advisory Committee to the Department of Public Welfare for further study, and that the committee be requested to report back to the Council as soon as they have completed their study for action of the Council. G. E. Rader, M.D., seconded the motion, which carried.

The Speaker called for a 10-minute recess at this time.

After reconvening, Dr. Boice continued:

Civil Defense Committee: The committee recommends approval as written.

This portion of the report was adopted.

Industrial Health Committee: The committee moves that the report be accepted. The committee is in favor of including the suggestion of industrial health in a future meeting of the State Society. It cannot be done in 1961, because the program has already been sufficiently formulated.

This portion of the report was adopted.

Legislative Committee: The committee moves that the Legislative Committee report be adopted with the exception that in the proposed change in the Medical Practice Act, Section 1 (b) be deleted.

W. A. Stark, M.D., moved that the House of Delegates postpone indefinitely action on acceptance of the proposed changes in the Medical Practice Act included in this committee's report. Alfred Blauw, M.D., seconded the motion, which was defeated, with four members voting in favor of the motion.

The motion of the reference committee was carried.

Medical-Legal Committee: The committee recommends approval of this report, and it is suggested that the objections of the Dona Ana County Medical Society may be met by having the members personally apply to the insurance company for authorization to be placed on their list of recommended physicians, thus avoiding the necessity for legislative action. We recommend that the Medical-Legal Committee investigate this possibility.

Dr. Boice moved that this recommendation be accepted. It was requested that this motion be voted on in two questions: The first, "the committee recommends approval of this report," was unanimously approved by the House of Delegates. The second, encompassing the remainder of the committee's suggestion regarding objections of the Dona Ana County Medical Society, was defeated.

Mental Health and Alcoholism Committee: We recommend that there be close cooperation between the New Mexico State Hospital and the private practitioners of medicine, and the Mental Health Committee establish procedures to implement this recommendation.

This portion of the report was adopted.

Public Health Committee Report: The committee recommends that Page 3, Paragraph 7 d, be changed to read: "A new Cancer Consultant Nurse may be assigned to the Public Health Laboratory at the request of the New Mexico Medical Society."

Roy Goddard, M.D., asked that this paragraph be withdrawn. Dr. Boice approved the request, and this is to be deleted from the Public Health Committee report.

Page 2, that the resolution be changed to read, after, Be It Resolved, add: That the New Mexico Medical Society recommends that the New Mexico Tuberculosis Coordinating Council, etc.

Dr. Boice moved that this recommendation be accepted. The motion carried.

Public Relations Committee: We move that the Public Relations Committee report be accepted, with the deletion of paragraph 5.

This portion of the report was adopted.

School Health Committee: No report received.

Supplemental reports referred to this committee:

The committee approves of Dr. Haynes' recommendation concerning the Legislative Committee, but recommends that the name of the committee be changed to "Legislative and Public Policy" Committee, rather than "Political Action."

This portion of the report was adopted.

Dr. Boice reported that the committee overlooked the resolution submitted by the Bernalillo County Medical Association requesting endorsement of the enactment of The Model State Civil Defense Act and the so-called "Good Samaritan Acts" by the next Legislature. The reference committee moved that this resolution be adopted. The motion carried.

Dr. Boice then moved the adoption of this report, with amendments, as a whole. The motion carried.

Dr. Boice expressed appreciation to the members of his committee for the time, thought and effort involved in submitting of this report.

J. A. Dillahunt, M.D., Chairman, Reference Committee on Miscellaneous Business, gave the following:

Report of the Reference Committee on Miscellaneous Business

We recommend that the House of Delegates express its appreciation to Eddy County Medical Society for its hospitality to the New Mexico Medical Society Interim Session of the House of Delegates.

This portion of the report was adopted.

The reference committee recommends that the report of the Accident and Prevention Committee be filed for information.

This portion of the report was adopted.

The committee recommends that the report of the American Medical Education Foundation Committee be commended and filed for information.

The Speaker reported this report will be filed.

Committee on Aging: No report received.

Report of the Liaison Committee to Allied Professions: Regarding that portion relating to the request of the New Mexico Visiting Nurses' Association, line 3, paragraph 3: This should be altered to read: "Visiting Nurses' Service of Albuquerque." In paragraph 4, line 4, the first word, "wouldn't" should read "would."

Regarding the request for endorsement, your reference committee believes that the inclusion of any paramedical services in Blue Shield benefits involves a precedent and principle departure so fundamental that it should be endorsed by this House of Delegates only when there is clear evidence of most pressing and vital public need for such inclusion. The proposed inclusion of services by the Visiting Nurses' Service of Albuquerque is not believed by your reference committee to be sufficiently urgent in this respect to justify your endorsement and the policy that would be thereby established.

This portion of the report was adopted.

It is further recommended that the committee be redesignated "Liaison Committee to Allied Professions and Voluntary Health Agencies," as suggested by the committee.

It is further recommended that the balance of the report be filed for information.

This portion of the report was adopted.

The committee recommends that the Maternal and Infant Mortality Committee be commended for its proposed professional education program, that the committee be redesignated the Maternal and Infant Mortality Committee, and that the report be filed for information.

The Speaker reported that the report would be filed.

The reference committee recommends that the report of the Medicare Adjudication Committee be filed, after deletion of the parenthetical phrase in paragraph 2, "(elective procedures requiring prior permission from the local Office before being performed)," as requested by the reporting Chairman.

This portion of the report was adopted.

The reference committee recommends that the report of the Rehabilitation Committee be filed for information.

The Speaker reported that the report would be filed.

The reference committee recommends that the report of the Student Loan Fund Committee be filed for information.

The Speaker reported that the report would be filed.

Dr. Dillahunt then moved the adoption of the committee's report as a whole. The motion carried.

Dr. Dillahunt expressed his appreciation to the members of his committee for the services performed in rendering this report.

Allan L. Haynes, M.D., President, expressed his personal appreciation and congratulations to the members of the House of Delegates for their efforts and the clarity of their instructions to the Council and officers, and observed that this would be of great assistance to the Council and officers.

The Speaker thanked all committees for their fine work.

There being no further business, the Third Interim Session of the House of Delegates adjourned without day.

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The Colorado State Medical Society

Rocky Mountain Cancer Conference,
July 12-13, 1961, Denver

OFFICERS—1960-1961—Terms of Officers and Committeemen expire at the Annual Session in the year indicated. Where no year is indicated the term is for one year only and expires at the 1961 Annual Session.

President: Cyrus A. Anderson, Denver.
President-elect: V. V. Anderson, Del Norte.
Vice President: Sam W. Downing, Denver.
Treasurer: William C. Service, Colorado Springs, 1962.
Constitutional Secretary: Howard T. Robertson, Denver, 1963.
Additional Trustees: Fred R. Harper, Denver, 1961; Walter M. Boyd, Greeley, 1961; Carl H. McLauthlin, Denver, 1962; J. Alan Shand, La Junta, 1963.
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Delegates to the American Medical Association: E. H. Munro, Grand Junction, Dec. 31, 1961; (Alternate, Harlan E. McClure, Lamar, Dec. 31, 1961); I. E. Hendryson, Denver, Dec. 31, 1961; (Alternate, Clare C. Wiley, Longmont, Dec. 31, 1961); Kenneth C. Sawyer, Denver, Dec. 31, 1962; (Alternate, Gatewood C. Milligan, Englewood, Dec. 31, 1962).
Speaker, House of Delegates: Heman R. Bull, Grand Junction.
Vice Speaker, House of Delegates: Fredrick Good, Denver.
Foundation Advocate: Walter W. King, Denver.

ADVISORY COMMITTEE: Cyrus W. Anderson, Denver, Chairman; V. V. Anderson, Del Norte; Kenneth H. Beebe, Sterling; James A. Stapleton, Denver; G. C. Milligan, Englewood; H. R. Bull, Grand Junction; Sam W. Downing, Denver, Vice Chairman; John H. Amesse, Denver; Jack D. Bartholomew, Boulder; H. Calvin Fisher, Denver; Bradford Murphey, Denver; Clare C. Wiley, Longmont; William R. Lipscomb, Denver.

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Advisory to the Auxiliary: Fred R. Harper, Denver, Chairman; Carl A. Swartz, Pueblo; Karl Arndt, Denver.

Code of Cooperation Committee: John S. Bouslog, Denver, Chairman; V. V. Anderson, Del Norte; Sidney E. Blandford, Denver; William M. Covode, Denver; Cyrus W. Anderson, Denver; Howard T. Robertson, Denver; Clyde E. Stanfield, Denver; Mr. Harvey T. Sethman, Denver.

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Committee on Committees: Vetalis V. Anderson, Del Norte, Chairman; Sam W. Downing, Denver; Carl H. McLauthlin, Denver.

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Montana Medical Association*

Interim Session, April 7-8, 1961

Helena

President: Raymond F. Peterson, Fullerton, Calif.†
President-elect: Everett H. Lindstrom, Helena.
Vice President: Harold W. Fuller, Great Falls.‡
Secretary-Treasurer: William E. Harris, Livingston.
Assistant Secretary-Treasurer: Albert L. Vadheim, Jr., Bozeman.
Executive Committee: Raymond F. Peterson, Butte; Everett H. Lindstrom, Helena; Harold W. Fuller, Great Falls; William E. Harris, Livingston; Albert L. Vadheim, Jr., Bozeman; Leonard W. Brewer, Missoula; Herbert T. Caraway, Billings.
Delegate to the A.M.A.: Paul J. Gans, Lewiston.
Alternate Delegate to the A.M.A.: S. C. Pratt, Miles City.
Executive Secretary: Mr. L. R. Hegland, P.O. Box 1692, Billings; telephone 9-2585.

Nevada State Medical Association

Annual Meeting, August 23-26, 1961

Reno

OFFICERS—1960-1961—Terms of Officers and Committeemen expire at the Annual Session in the year indicated. Where no year is indicated the term is for one year only and expires at the 1961 Annual Session.

President: Wesley W. Hall, Reno.
President-elect: James N. Greear, Jr., Reno.
Secretary-Treasurer: William A. O'Brien, III, Reno.
Delegate to A.M.A.: Wesley W. Hall, Reno; alternate: Earl N. Hillstrom, Reno.
Immediate Past President: Ernest W. Mack, Reno.
Executive Committee: Wesley W. Hall, Reno; James N. Greear, Jr., Reno; Ernest W. Mack, Reno; William A. O'Brien, III, Reno; Earl N. Hillstrom, Reno; John M. Moore, East Ely; John M. Read, Elko; William M. Tappan, Reno; Thomas S. White, Boulder City.
Executive Secretary: Mr. Nelson B. Neff, P. O. Box 2790, Reno; telephone FA. 3-6788.

ARRANGEMENTS AND PROGRAM: Gilbert G. Lenz, Chairman, Reno; Robert F. Biglin, Reno; Frederick G. Bills, Reno; Edwin Cantlon, Reno; Harry B. Gilbert, Reno; Charles D. Lannnig, Reno; George A. Miners, Henderson; John M. Moore, East Ely; Lowell J. Peterson, Reno; John M. Read, Elko; John P. Sande, Reno; Richard C. Sheretz, Reno; Thomas S. White, Boulder City.
CONSTITUTION AND BY-LAWS: William A. O'Brien, III, Chairman, Reno; Stanley L. Hardy, Las Vegas; Leslie A. Moren, Elko; Lowell J. Peterson, Reno; Walter F. Quinn, Reno; Roland W. Stahr, Reno.
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FINANCE: Earl N. Hillstrom, Chairman, Reno; William A. O'Brien, III, Reno; Gerald J. Sylvain, Las Vegas.
WOMAN'S AUXILIARY ADVISORY: L. J. Sandars, Chairman, Reno; Ralph W. Hemington, Las Vegas; Robert Locke, Reno; John M. Moore, East Ely; Richard A. Petty, Carson City; B. A. Winne, Reno.
NECROLOGY: David C. Lambird, Chairman, Sparks; Reed Anderson, Ely; Mary H. Fulstone, Smith Valley; George S. Weiss, Winnemucca; Clare W. Woodbury, Las Vegas.
MEDICAL SCHOOL: Vernon Cantlon, Chairman, Reno; Fred M. Anderson, Reno; Louis E. Lombardi, Reno; Ernest W. Mack, Reno; William A. O'Brien, III, Reno; Carl Peterson, Las Vegas; Lowell J. Peterson, Reno; Glenn Tueller, Las Vegas.
PROFESSIONAL EDUCATION: David S. Thompson, Chairman, Reno; Emanuel Berger, Reno; Frederick D. Elliott, Reno; Gilbert G. Lenz, Reno; Robert M. Rudisill, Reno; Hale B. Slavin, Las Vegas.
HOSPITAL: John P. Sande, Chariman, Reno; John C. Becker, Reno; Hugh S. Collett, Elko; James B. French, Boulder City; John R. McDaniel, Jr., Fallon; Tom N. Mullis, Reno; Adolph Rosenauer, Reno; Kenneth F. Smith, Las Vegas.
MENTAL HEALTH: Leslie H. Gould, Chairman, Reno; Emanuel Berger, Reno; Raymond M. Brown, Reno; Richard W. Brown, Reno; Joseph L. Daly, Jr., Reno; Charles E. Fleming, Jr., Reno; Sidney J. Tillim, Reno; Adrien Ver Brugghen, Las Vegas.
MATERNAL HEALTH: Paul O. Wiig, Chairman, Reno; Everett C. Freer, Las Vegas; Mary H. Fulstone, Smith Valley; Dana D. Little, Reno; Donald I. Mohler, Reno; Robert L. Stewart, Reno; Kenneth E. Turner, North Las Vegas; George S. Weiss, Winnemucca.
CHILD HEALTH: John E. Palmer, Chairman, Reno; Eugene H. Bastien, Elko; Thaddeus W. Cap, Las Vegas; Charles C. Hyde, Battle Mountain; Olga L. Kipanidze, Reno; Frances Landreth, Reno; Grant Lund, Las Vegas; Emerson K. McVey, Elko; William E. Pasutti, Reno; Frank W. Samuels, Reno.
CRIPPLED CHILDREN'S ADVISORY: T. C. Harper, Chairman, Reno; Emanuel Berger, Reno; William J. Champion, Reno; M. J. Kirkeeng, Las Vegas; Martin W. Payne, Las Vegas; John G. Scott, Reno; William A. Teipner, Reno.
MEDICAL ADVISORY TO VOCATIONAL REHABILITATION: Richard A. Petty, Chairman, Carson City; Fred M. Anderson,

*Committee lists for all participating states will appear in subsequent issues.
†Resigned November 1, 1960.
‡Assumed the duties of the President, November 1, 1960, for the unexpired term of Dr. Peterson.

Reno; Richard W. Brown, Reno; V. E. Elliott, Fallon; James N. Greear, Jr., Reno; Richard D. Grundy, Carson City; Julius Jenson, Las Vegas; John M. Read, Elko; William B. Ririe, McGill; Adolph Rosenauer, Reno; Jack P. Sargent, Reno; David S. Thompson, Reno.

ARTHRITIS: Robert K. Myles, Chairman, Reno; John C. Becker, Reno; Claude M. Belcourt, Reno; Dwight L. Hood, Reno; Gerald W. Jones, Las Vegas; Francis M. Kernan, Reno; Harry McKinnon, Las Vegas.

AGING: Francis M. Kernan, Chairman, Reno; Paul J. Del Giudice, Elko; John H. DeTar, Reno; John DiFiore, Las Vegas; Karl S. Hazeltine, Jr., Las Vegas; Robert K. Myles, Reno; J. Stephen Phalen, Reno; Lyman F. Shurtliff, East Ely; Sidney J. Tillim, Reno.

MEDICARE ADVISORY: Arthur E. Scott, Chairman, Reno; J. M. Edmiston, Reno; Frederick D. Elliott, Reno; Everett C. Freer, Las Vegas; T. C. Harper, Reno; Albert C. Merkin, Las Vegas; Clare C. Wolf, Reno.

PUBLIC ASSISTANCE MEDICAL CARE ADVISORY: Richard C. Sheretz, Chairman, Reno; V. E. Elliott, Fallon; Earl N. Hillstrom, Reno; Charles D. Lanning, Reno; Robert P. O'Donnell, Las Vegas; John M. Read, Elko; Arthur E. Scott, Reno.

MEDICAL ASSISTANTS ADVISORY: Chester C. Lockwood, Chairman, Las Vegas; John R. Ervin, Co-Chairman, Reno; Edwin Cantlon, Reno; A. J. Dingacci, Fallon; James N. Greear, Jr., Reno; Noah Smernoff, Reno.

HOME AND HIGHWAY SAFETY: John H. DeTar, Chairman, Reno; Robert V. Broadbent, Reno; Samuel T. Clarke, Reno; John R. Connolly, Boulder City; Roy N. Eklund, Las Vegas; Gawinn B. Gardner, Las Vegas; Lynn B. Gerow, Reno; Charles J. Kilduff, Las Vegas; George F. Magee, Reno; Roy M. Peters, Reno; Roderick Sage, Reno; David E. Williams, Reno.

BUILDING: Earl N. Hillstrom, Chairman, Reno; Edwin Cantlon, Reno; Stanley L. Hardy, Las Vegas; John M. Moore, East Ely; William A. O'Brien, III, Reno; Athur E. Scott, Reno.

ATHLETICS AND SCHOOL HEALTH: John M. Edmiston, Chairman, Reno; John W. Brophy, Reno; Frederick L. Coddington, Reno; Joseph C. Elia, Reno; Frederick D. Elliott, Reno; Richard D. Grundy, Carson City; Charles D. Lanning, Reno; Morse W. Little, Reno; Ernest W. Mack, Reno; James L. Monnahan, Elko; Donald Romeo, Las Vegas; James H. Swartzfager, Jr., Las Vegas.

ALCOHOLISM: Harvey C. Waters, Chairman, Las Vegas; Charles E. Fleming, Jr., Co-Chairman, Reno; David D. Carr, Las Vegas; Robert C. Crosby, Reno; Joseph L. Daly, Jr., Reno; E. F. Hanson, Reno; Lucien H. Imboden, Las Vegas; Silas E. Ross, Jr., Reno; Horace B. Taylor, Reno.

NEVADA MEDICAL CARE, INC.: Arthur E. Scott, President, Reno; John M. Read, First Vice President, Elko; Lorne M. Phillips, Second Vice President, Henderson; Joseph M. George, Jr., Secretary-Treasurer, Las Vegas; John M. Moore, Member-at-Large, East Ely.

BLOOD BANK: V. A. Salvadorini, Chairman, Reno; James Clark. Las Vegas; Joseph R. Fouts, Las Vegas; Lawrence Parsons, Reno; Robert M. Taylor, Las Vegas.

ROCKY MOUNTAIN MEDICAL CONFERENCE: Thomas S. White, Chairman, Boulder City, 1963; Harold L. Boyer, Las Vegas, 1962; Willard P. McCormick, Reno, 1961; George A. Miners, Henderson, 1961; William M. Tappan, Reno, 1965; Adrien Ver Brugghen, Las Vegas, 1964.

HISTORIAN: Frederick W. Meng, Chairman, Reno; Grover O. Bradley, Reno; Roy N. Eklund, Las Vegas; John A. Fuller, Reno; Ontie C. Hovenden, Carson City; Vinton A. Muller, Reno; Frank V. Rueckl, Winnemucca.

New Mexico Medical Society*

Annual Meeting, May 17-20, 1961

Santa Fe

President: Allan L. Haynes, Clovis.
President-elect: William E. Badger, Hobbs.
Vice President: R. C. Derbyshire, Santa Fe.
Secretary-Treasurer: T. L. Carr, Albuquerque.
Speaker, House of Delegates: C. Pardue Bunch, Artesia.
Vice Speaker, House of Delegates: Omar Legant, Albuquerque.
Councilors: William Hossley, Deming, 1961; Guy E. Rader, Albuquerque, 1961; Robert P. Beaudette, Raton, 1962; William R. Oakes, Los Alamos, 1962; John McCulloch, Farmington, 1963; George Prothro, Clovis, 1963; Gerald Slusser, Artesia, 1963.
Delegate to American Medical Association: Earl L. Malone, Roswell; Alternate: Leland S. Evans, Las Cruces.
Executive Secretary: Mr. Ralph R. Marshall, 220 First National Bank Building, Albuquerque; telephone CH. 2-2102.

The Utah State Medical Association

Annual Session, September 13-15, 1961

Salt Lake City

President: Wallace S. Brooke, Salt Lake City.
President-elect: Ralph E. Jorgenson, Provo.
Secretary: John F. Waldo, Salt Lake City, 1963.
Treasurer: Edward R. McKay, Salt Lake City, 1963.
Councilors: Box Elder, D. L. Bunderson, Brigham City, 1960; Cache Valley, C. J. Daines, Logan, 1960; Carbon County, A. R. Demman, Helper, 1961; Central Utah, LaMar H. Stewart, Gunnison, 1962; Salt Lake County, R. W. Sonntag, Salt Lake City, 1960; Southern Utah, L. V. Broadbent, Cedar City, 1963; Uintah Basin, Vernon C. Young, Vernal, 1961; Utah County, Richard A. Call, Provo, 1963; Weber County, Wendell J. Thomson, Ogden, 1961.
Executive Committee: Wallace S. Brooke, Salt Lake City; I. Bruce McQuarrie, Ogden; Ralph E. Jorgenson, Provo; John F. Waldo, Salt Lake City; Edward R. McKay, Salt Lake City.
Delegate to American Medical Association: Drew M. Petersen, Ogden; Alternate: Stanley R. Child, Salt Lake City.
Executive Secretary: Mr. Harold Bowman, 42 South Fifth East Street, Salt Lake City 2; telephone EL. 5-7477.
See November, 1960, issue for complete list of committees.

Wyoming State Medical Society*

Annual Session, September 18-21, 1961

Jackson Lake Lodge

President: Francis A. Barrett, Cheyenne.
President-elect: Frederick H. Haigler, Casper.
Vice President: S. J. Giovale, Cheyenne.
Secretary: John H. Froyd, Worland.
Treasurer: C. D. Anton, Cheyenne.
Delegate to A.M.A.: B. J. Sullivan, Laramie; Alternate Delegate to A.M.A.: R. W. Holmes, Casper.
Executive Secretary: Mr. Arthur R. Abbey, Box 2266, Cheyenne; telephone 632-5525.

*Committee lists for all participating states will appear in subsequent issues.